SEABREEZE COUNSELING CENTER LLC
Bethany Stapinski, LCSW, QS
420 N. Halifax Ave, Suite 110
Daytona Beach, FL 32118
seabreezecounselingcenter@gmail.com
www.seabreezecounselingcenter.com

New Client Intake Questionnaire

Please fill out the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

Name:_____ Age: _____ DOB: _____

Preferred/Nickname: _____ Gender: _____

School: _____ Grade: _____

Parent/Legal Guardian (if under 18): _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____

Home Phone: _____ May we leave a message? ☐ No ☐ Yes

Cell/Work/Other Phone: _____ May we leave a message? ☐ No ☐ Yes

Email: _____

Primary Care Physician Name: _____ Phone: _____

Emergency Contact Name: _____

Relationship: _____Phone: _____

Personal Mental Health History

1. Have you previously received any type of mental health services *(psychotherapy, psychiatric services, etc.)?* ☐ No ☐ Yes
   If yes, who was your previous therapist/practitioner: _____

2. Have you ever been diagnosed with a Mental Health Disorder? ☐ No ☐ Yes
   If yes, please list diagnosis and the approximate age you were when diagnosed

DIAGNOSIS:	AGE:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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3. Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes

If yes, please list and provide dates: _____
_____
_____
_____

4. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes
If yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes
If yes, when did you begin experiencing this? _____

6. Please indicate if you have experienced any of the following symptoms in the **last 30 days**:

Depressed mood	☐ No ☐ Yes	Racing thoughts	☐ No ☐ Yes
Excessive worry	☐ No ☐ Yes	Unable to enjoy activities	☐ No ☐ Yes
Impulsivity	☐ No ☐ Yes	Sleep pattern disturbance	☐ No ☐ Yes
Anxiety attacks	☐ No ☐ Yes	Increase risky behavior	☐ No ☐ Yes
Avoidance	☐ No ☐ Yes	Loss of interest	☐ No ☐ Yes
Increased libido	☐ No ☐ Yes	Decreased libido	☐ No ☐ Yes
Suspiciousness	☐ No ☐ Yes	Concentration/forgetfulness	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes	Decrease need for sleep	☐ No ☐ Yes
Change in appetite	☐ No ☐ Yes	Excessive energy	☐ No ☐ Yes
Excessive guilt	☐ No ☐ Yes	Increased irritability	☐ No ☐ Yes
Delusions	☐ No ☐ Yes	Hallucinations	☐ No ☐ Yes
Suicidal Thoughts	☐ No ☐ Yes	Suicidal Actions	☐ No ☐ Yes
Increased Anger	☐ No ☐ Yes	Self-harming behaviors	☐ No ☐ Yes
Paranoia	☐ No ☐ Yes	Increased tearfulness	☐ No ☐ Yes

Use this space to provide any additional details on any symptoms you indicated yes for above: _____
_____
_____

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_____

_____

General Health Information

1. How would you rate your current physical health? *(Circle one)*

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

_____

2. Are you currently taking any prescription medications or vitamin supplements? ☐ No ☐ Yes

If yes, please list name, dose, and frequency:

_____

_____

_____

_____

3. How would you rate your current sleeping habits? *(Circle one)*

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

4. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

5. Please list any difficulties you're experiencing with your appetite or eating problems: _____

_____

6. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe: _____

7. Do you drink alcohol more than once a week? ☐ No ☐ Yes

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8. Do you use medicinal marijuana? ☐ No ☐ Yes

9. How often do you engage in *recreational* drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes *If yes,* how long? _____
Please list any challenges or stressors within the relationship _____
_____
_____

11. What significant life changes or stressful events have you experienced recently? _____
_____
_____
_____
_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided *(child, father, grandmother, etc.)*

ADHD	☐ No	☐ Yes	Relationship: _____
Alcohol/Substance Abuse	☐ No	☐ Yes	Relationship: _____
Anxiety	☐ No	☐ Yes	Relationship: _____
Autism	☐ No	☐ Yes	Relationship: _____
Bi Polar Disorder	☐ No	☐ Yes	Relationship: _____
Depression	☐ No	☐ Yes	Relationship: _____
Domestic Violence	☐ No	☐ Yes	Relationship: _____
Eating Disorders	☐ No	☐ Yes	Relationship: _____
Obsessive Compulsive	☐ No	☐ Yes	Relationship: _____
Schizophrenia	☐ No	☐ Yes	Relationship: _____
Suicide Attempts	☐ No	☐ Yes	Relationship: _____

Additional Information

1. Are you currently employed? ☐ No ☐ Yes *If yes,* do you work: ☐ Full Time ☐ Part Time
Occupation: _____ Employer: _____

What is your work location? ☐ Away from home ☐ In Home ☐ Combination/Hybrid

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Do you enjoy your work? ☐ No ☐ Yes

Is there anything stressful about your current work? _____

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief: _____

3. How would you describe your learning style? *(Circle all that apply)*

Visual *(seeing)* Auditory *(hearing)* Read/Write Tactile *(doing)*

3. What do you consider to be some of your strengths? _____

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses? _____

_____

_____

5. What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

6. Is there anything else you would like me to know prior to your session? _____

_____

_____

_____

_____

Who were you referred by? (if any): _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS PAPERWORK.

I LOOK FORWARD TO MEETING WITH YOU 😊

-Bethany Stapinski, MSW, LCSW

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Seabreeze Counseling Center, LLC Practice Policies

EMERGENCY & CRISIS

If you are experiencing a mental health or physical emergency, please call 911 or report to your nearest emergency room. If you are experiencing a behavioral health crisis or thoughts/behaviors of self-harm or harm to others, immediately call 911 and/or the National Suicide and Crisis Hotline by dialing 988 from any phone.

APPOINTMENTS AND CANCELLATIONS

PLEASE ARRIVE ON TIME FOR YOUR APPOINTMENT. THE OFFICE DOOR IS LOCKED TO ENSURE PROVIDER AND CLIENT SAFETY. PLEASE RING THE OUTSIDE DOORBELL WHEN YOU ARRIVE AND FOLLOW THE INSTRUCTIONS LISTED. PLEASE CONTACT ME IF YOU HAVE ANY ISSUES.

If you are not able to keep your scheduled appointment, please contact my office via phone, text, or email a minimum of 24 hours prior to your scheduled appointment day/time. Failure to do so will result in a non-refundable cancellation fee of $100.00. Future appointments will not be scheduled until cancellation fees have been remitted.

- Appointments made less than 24 hours in advance of day/time are subject to the full cancellation fee if they elect to cancel or reschedule due to the absence of a 24-hour cancellation window.
- If you are late for a session, you will receive the remaining amount of time in your scheduled appointment which will result in a shorter session. (Example: if you have a 60-minute appointment that begins at 8:00am, and you arrive at 8:15am, you will only receive 45 minutes of services and your session will still end at 9:00am).
- Clients that are more than 30 minutes late for a session will be re-scheduled and charged the standard cancellation fee of $100.00.

The standard meeting time for a psychotherapy/ counseling session is 52-56 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to extend your session time needs to be discussed with the therapist in order for additional time to be scheduled in advance. *This cancellation policy is necessary because a time commitment is being made to you, and because of that this time is held exclusively for you. The time slot cannot be filled when proper 24-hour notice is not given by you, the client.*

COURT & LEGAL REQUESTS

When appearing in court the rate is $500 for the first 3 hours, with a 3-hour minimum. This initial fee includes appearing in court, driving to and from the court (additional fees apply for out-of-county travel), and reviewing related documents. If the time exceeds more than 3 hours, each additional hour

will be at the rate of my counseling fee ($120.00 an hour). The court fee is required to be paid in advance and is non-refundable.

There will be a charge of $50.00 per client requested court letter. Letters will only be provided to individuals that the client has completed a signed HIPPA Release of Information for. Client is responsible for providing the clinician with accurate name and contact information for the requested addressee.

PRIVATE PAY & ADDITIONAL FEES

Clients not using insurance benefits: $120.00 per individual session (52-56 minutes)
Clients not using insurance benefits: $160.00 per family/couples session
Late Cancellation and No-Show Fee: $100.00
Court Appearance (including subpoena): $500.00 (first 3 hours, then $120.00 each additional hour)
Court/Legal Letters: $50.00 per letter
Record Requests: Printed records can be requested at a fee of $.50 per page

PAYMENT

Session fees and co-payments can be made by major credit cards or cash. No checks will be accepted. Payment is due when services are rendered. If using the Headway Platform, you will be charged per their user agreement when services are delivered. You are required to have a credit card on file with the Headway Platform if you have an account with them.

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please either text, leave a message on my voice mail or email me at seabreezecounselingcenter@gmail.com. I am often not immediately available; however, I will attempt to return your call/text/email within 24 business hours (excluding weekends and holidays). I do not offer a 24-hour on call service and communications are not monitored outside of my standard business hours. In the event of an emergency or crisis please call 911 or visit any local emergency room. If you are in crisis, please contact 911 and/or the National Suicide and Crisis Hotline at 988.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can discuss it further.

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ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

(2) All existing confidentiality protections are equally applicable.

(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus

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include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents' what information is appropriate for them to receive and which issues are more appropriately kept confidential. Parents of clients under the age of 16 must remain on the property while their child is in session. Parents will be asked to review and sign a Parent Investment Statement to ensure their understanding of the therapy process, confidentiality and the importance of their engagement in and outside of therapy.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

ADULT CLIENTS ONLY:

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

MINOR CLIENTS ONLY:

_____	_____
Print Client Name	Client DOB
_____	_____
Print Parent/Legal Guardian Name	Relationship to Client
_____	_____
Parent/Legal Guardian Signature	Date

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Informed Consent for Psychotherapy

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

THE THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There is no miracle cure. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

CONFIDENTIALITY

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

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If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please contact my office via phone, text, or email a minimum of 24 hours prior to your scheduled appointment day and time. Failure to do so will result in a non-refundable cancellation fee of $100.00. Future appointments will not be scheduled until cancellation fees have been remitted.

PRACTITIONER INFORMATION

I hold a Master's Degree in Social Work (MSW) from The University of New England and a Bachelors of Science Degree (BS) from The University of Central Florida. I am a Licensed Clinical Social Worker (LCSW) by the State of Florida Health Department. License number SW20067. I am a Florida Supreme Court Certified Family Law Mediator.

COURT & LEGAL REQUESTS

When appearing in court the rate is $500 for the first 3 hours, with a 3-hour minimum. This initial fee includes appearing in court, driving to and from the court (additional fees apply for out-of-county travel), and reviewing related documents. If the time exceeds more than 3 hours, each additional hour will be at the rate of my counseling fee ($120.00 an hour). The court fee is required to be paid in advance and is non-refundable. Please consult with your attorney the possibility of letter submission prior to asking them to issue a court subpoena. There are many cases where letter submission is appropriate and sufficient to the court.

There will be a charge of $50.00 per client requested court letter. Letters will only be provided to individuals that the client has completed a signed HIPPA Release of Information for. Client is responsible for providing the clinician with accurate name and contact information for the requested addressee.

MINORS

When a minor is receiving services a parent or legal guardian must remain on the premises during the session. A waiting area is provided for parents/guardian(s). Minors are given the same confidentiality rights as adults. The clinician will not serve as an informant for the parents/guardian(s) unless confidentiality is required to be broken due to any of the criteria contained in #1-7 above in the confidentiality section of this document. Exceptions are also made if the minor client gives consent to sharing certain information.

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BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

ADULT CLIENTS ONLY:

_____ _____
Print Client Name Client DOB

_____ _____
Client Signature Date

MINOR CLIENTS ONLY:

_____ _____
Print Client Name Client DOB

_____ _____
Print Parent/Legal Guardian Name Relationship to Client

_____ _____
Parent/Legal Guardian Signature Date

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Notice of Privacy Practices

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

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on 05/01/2023

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health

care providers and referrals of a patient for health care from one health care provider to another.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.
b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the

same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence
operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the

SEABREEZE COUNSELING CENTER LLC
Bethany Stapinski, LCSW, QS
420 N. Halifax Ave, Suite 110
Daytona Beach, FL 32118
seabreezecounselingcenter@gmail.com
www.seabreezecounselingcenter.com

existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice-- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

ADULT CLIENTS ONLY:

_____ _____
Print Client Name Client DOB

_____ _____
Client Signature Date

MINOR CLIENTS ONLY:

_____ _____
Print Client Name Client DOB

_____ _____
Print Parent/Legal Guardian Name Relationship to Client

_____ _____
Parent/Legal Guardian Signature Date

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HIPAA Release of Information Form

I, _____, give my permission for **SEABREEZE COUNSELING CENTER, LLC** to share my protected health information with the following individual(s) or organization(s)

Name: _____ Organization: _____

Address: _____

Phone: _____ Email: _____

INFORMATION TO BE DISCLOSED:

□ Disclose my complete mental health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

□ Disclose my complete health record except for the following *(please specify below):*

_____

METHOD OF DISCLOSURE AUTHORIZED: *(check all that apply)*

□ Verbal/Email Consult for Coordination of Care

□ Hard copy (paper) □ Electronic copy or access via a web-based portal

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them. This authorization to share my health information is valid for **1 YEAR** *from the date signed. I can revoke this authorization to share my health data at any time and can do so by submitting a request in writing to* **SEABREEZECOUNSELINGCENTER@GMAIL.COM** *I understand that, in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV. I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.*

_____ _____
Print Client Name Client DOB

_____ _____
Client Signature Date

_____ _____
FOR MINORS -Print Parent/Legal Guardian Name Relationship to Client

_____ _____
FOR MINORS -Parent/Legal Guardian Signature Date