Hope Restored Counseling OF FLORIDA LLC

Intake Form-Potential Client

Welcome! We are please you have chosen ***Hope Restored Counseling of Florida, LLC.,*** to help you achieve emotional and nutritional health. Thank you! We are committed to making our work together as effective and helpful as possible. We believe that time spent in counseling is a powerful investment in your overall health.

After receiving this form, you will be contacted to set up a 10-minute phone consultation to ensure that ***Hope Restored Counseling of Florida, LLC.,*** will be a good fit for providing your counseling needs.

Please complete and return this form either by faxing (HIPAA Compliant) **863.777.5412** or emailing (not guaranteed HIPAA Compliant) **hoperestoredfl@gmail.com**

Date: ____ / ____ / _____

First Name: _____ **Last Name**: _____ **Nick Name**: _____

Gender: _____ **Date of Birth**: _____ **Age**: _____

Address: _____ **City**: _____ **State**: _____ **Zip Code**: _____

Mailing address (if different): _____ **City**: _____ **State**: _____ **Zip**: _____

Best Contact Number: (____) _____ **Is it okay to leave a detailed message?** ☐ **Yes** ☐ **No**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Living with Partner

Race / Ethnicity: (Check all that apply)
☐ Asian/Pacific Islander ☐ African-American/Black ☐ Native American
☐ Caucasian/White ☐ Latino/Hispanic ☐ Decline to Specify

Emergency Contact Information

(Please update this information as needed. This will be the information used, should the need arise.)

Name: _____ **Relationship to you:** _____ **Phone #:** (_____) _____

Address: _____ **City:** _____ **State:** _____ **Zip Code**: _____

Primary Care Provider (PCP) (Provide if you were referred by your PCP)

PCP Name: _____ **PCP Group** (If applicable): _____

PCP Phone #: (____)_____ **PCP Fax #:** _____

PCP Address: _____ **City**: _____ **State:** _____ **Zip Code**: _____

Hope Restored Counseling OF FLORIDA LLC

Insurance Information: (Provide if you will be seeking reimbursement from your carrier)

Primary Insurance: _____ **Policy Holder:** _____

Policy Holder Date of Birth: ___ / ___ / _____ **Relationship to Client:** _____

Policy Holder Address: _____

City: _____ **State:** _____ **Zip:** _____

Policy Number: _____ **Group Number:** _____

What issues/concerns are you seeking counseling to manage?

_____

_____

Please mark the times you are available: Availability may be limited.

Every effort will be made to accommodate your availability:

	Monday	Tuesday	Wednesday	Thursday	Friday
8 am					
9 am					
10 am					
11 am					
12 pm					
1 pm					
2 pm					
3 pm					
4 pm					
5 pm					

☐ None of these times are convenient for my schedule. Need: _____

Communication Authorization:

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made to alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Hope Restored Counseling of Florida, LLC, **has permission to contact me at the following:** **(CHECK ALL THAT APPLY)**

Hope Restored Counseling OF FLORIDA LLC

☐ Home telephone # _____

Okay to leave a message with detailed information	☐ Yes	☐ No
Okay to leave a message with person answering	☐ Yes	☐ No

☐ Cell phone # _____

Okay to send text messages	☐ Yes	☐ No
Okay to leave a message with detailed information	☐ Yes	☐ No
Okay to leave a message with person answering	☐ Yes	☐ No

☐ Email Address: _____

Okay to communicate via email address	☐ Yes	☐ No
Okay to send counseling correspondences	☐ Yes	☐ No

All written correspondence, such as statements, will be emailed, unless otherwise indicated.

Third party receipts, such as square, and from the therapist via email are not guaranteed HIPAA compliant.

☐ I **do** give permission to receive counseling correspondence via email. I will not hold ***Hope Restored Counseling of Florida, LLC.,*** liable should there be a HIPAA violation.

☐ I **do not** give permission to receive counseling correspondence via email.

_____ _____ _____

(Signature) (Printed Name) (Date)

The information provided in this form will be held confidential is accordance with the HIPAA laws.

We look forward to working with you

Hope Restored Counseling of Florida, LLC
Office: 863.712.0877 **Fax:** 863.777.5412
Mailing Address: PO Box 90633 Lakeland, Fl. 33804-0633 **Office:** 2033 E. Edgewood Dr., Suite 4 Lakeland 33803
Email: hoperestoredfl@gmail.com Website: www.hoperestoredfl.com