Hope Restored Counseling
OF FLORIDA LLC

Intake Form

Welcome! We are please you have chosen *Hope Restored Counseling of Florida, LLC.,* to help you achieve emotional and nutritional health. 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.

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**: _____

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

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

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

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

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Policy Holder Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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

Communication Authorization

The HIPAA privacy regulations 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)**

☐	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

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