Jamie F. Wintz, LMHC, LLC
Psychotherapist

8259 N. Military Tr. Suite 14, Palm Beach Gardens, FL 33410

tel. 352-514-2562
fax. 561-784-6999
Therapist@JamieWintz.com
www.jamiewintz.com

Informed Consent for Treatment

For the purposes of this informed consent for treatment:

- Jamie F. Wintz, LMHC, LLC. will now be abbreviated as follows "JW".
- The person(s) seeking treatment/being seen in JW's counseling office and/or the parent/the guardian thereof will now be abbreviated/referred to collectively and or interchangeably as "the client".
- Health insurance companies will be abbreviated to "Ins. Co." Employee Assistance Programs will be abbreviated to "EAP". Appointment will be abbreviated to "appt".

About Insurance and EAP Companies
(The client always has the right to pay privately for JW's services to avoid the complexities which are described below.)

- The client is responsible for contacting the client's EAP or Ins. Co. to verify and understand JW's status as an "in network" or "out of network" provider for the client's plan, the limits of the client's coverage for mental health/ behavioral health services, as well as the client's co-payments and deductibles, and obtaining preauthorization, if required, as applicable.

The client understands that:

- mental health providers are required to submit psychiatric diagnosis &/or a "treatment plan" including counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, medication prescription and monitoring, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date;
- if an Ins. Co. or EAP elects to audit its particular clients charts at the therapist's practice they may also discover description of the presenting problem, members within the client's household & quality of relationships, current medical information, therapeutic interventions, & other data in the medical record (e.g. medical session notes);
- Ins. Co. & EAPs reserve the right to audit their member's charts at any time (i.e. to monitor compliance for "medically necessary" treatment);
- once this information is submitted to the Ins. Co. &/or EAP it becomes a part of the client's permanent medical record & it may be computerized or entered into a national medical information data bank. Once, submitted to the EAP &/or Ins. Co., JW has nothing to do with how it's used or maintained by the EAP &/or Ins. Co. & cannot be held liable for how the information is used thereafter by the EAP &/or Ins. Co;
- if the client does not want to release diagnostic information to the Ins. &/or EAP Co., the client will not give JW Ins. Co. or EAP information. If the client has already given JW permission to bill the Ins. Co. or EAP and the client no longer wishes to utilize insurance or EAP benefits, the client must advise JW of this in writing. JW cannot be held responsible for information or claims already submitted prior to the client's written request;
- each Ins. & EAP Co. have contracted reimbursement rates established with their contracted providers. If a provider chooses to contract with an Ins. or EAP Co., that provider has agreed to accept their reimbursement rates regardless of the counselor's billed rates. The counselor cannot balance bill the client for sessions as per the counselor's contract with the Ins. or EAP Co. The provider can bill the client for non-Ins./EAP covered services (i.e. late cancel/no show fees, court-related fees, fees related to copying/faxing/mailing documentation, etc.);

About Fees & Payments

- JW reserves the right to periodically adjust these fees. The client will be notified of any fee adjustments in advance if known by JW. In addition, these fees may be adjusted by contract with insurance companies or other third party payors or by agreement with JW.
- Please be aware that insurance companies have restrictions on what they will cover and not all issues that may bring someone to therapy are covered by insurance. Whenever possible JW will notify the client ahead of time if JW is aware of said restrictions.

- **JW's billable rates for treatment are as follows:**
  - **Diagnostic Intake/Interview 60-75 min. + administrative time (90791): $175**
  - **Individual Psychotherapy 45 min. (90834): $100**
  - **Conjoint/Family Psychotherapy (90847): $125**
  - **Family Psychotherapy without the Client Present (90846): $125**
  - **Individual Psychotherapy for 60 minutes (90837): $125**
- JW offers a small sliding scale (reduction in billable rates for treatment) for existing clients who, during the course of treatment, lose insurance coverage, switch to an insurance plan not accepted by JW, and/or experience a reduction in ability to pay due to job loss.
- Payment (regardless of whether it's a copayment, coinsurance, deductible, or private payment) is due at the time of session. The client is ultimately responsible for the payment of fees (not the EAP &/or Ins. Co.). Should the EAP &/or Ins. Co. elect not to pay for any reason (i.e. if the client did not attain an authorization for sessions from Ins. Co.), these fees will be due within 30 days of the EAP/Ins. Co.'s rejection.
- **The client understands that JW only typically accepts cash or check (at this time the credit card option is only reserved for collecting cancellation/no-show fees, outstanding fees, or for emergencies).** If the client's check bounces, the client will be asked to pay cash from that point forward for any further sessions & will be asked to pay any fees charged by JW's bank for the bounced check (typically $32).
- The client understands that the client (not the Ins. Co.&/or EAP) will be held responsible for the following fees should they occur and that the client will be notified ahead of time by JW if the client is to be charged:
  - **$250 an hour if JW is forced to appear in court on the client's behalf via a subpoena. The client shall be billed per whole hour for JW's time related to court-appearance/testimony, wait time, travel time, deposition, document/testimony preparation time, attorney meetings, and/or court-related telephone calls. All fees are rounded up to the nearest whole hour. If JW is forced to appear in court on the client's behalf via a subpoena, the client agrees to pay upfront and prior to JW's court-appearance, a non-refundable retainer fee in the amount of $1000 (which represents 4 hours of service). Should JW be required to perform court-related services in excess of 4 hours, the client acknowledges that he/she will be billed $250/hour for any additional court-related services performed by JW. The client acknowledges that this document serves as a contract for professional services so written and agreed to between the client and JW, and the client (not the attorney, insurance company, or any other party) will be held liable for full payment of JW's court-related fees.**
  - $25 per quarter hour with a quarter hour minimum for outside of session contacts with JW (i.e. phone calls, emails, etc. initiated by the client) surpassing 15 minutes in length and/or that are excessive in nature.
  - $100 per hour (fee rounded to the nearest whole hour) should JW be requested or required to write up case summaries to other professionals/parties regarding the client's care. Charges associated with these services will be due prior to the other professionals/parties receiving said documentation.
  - $1 per page should the client's records be requested to be faxed, mailed, &/or emailed to other professionals/parties regarding the client's care. Charges associated with these services will be due prior to the other professionals/parties receiving said documentation.
  - postage to send said documents to other parties.
- The client understands that if the client does not fulfill the client's financial obligations within 30 days (unless otherwise arranged with JW), JW has the right to pursue payment via a collections agency (JW has a collections business agreement with IC System) &/or JW has the right to report outstanding balances to the credit bureaus, &/or JW has the right to pursue payment via small claims court.
- The client understands that failure to pay JW's fees for services rendered will result in immediate termination of treatment, without exception.

About Appointment Cancellations, Reschedules and No Shows

The client understands appointments must be cancelled or rescheduled with a minimum notice of 24-hours. Notice of cancellations and reschedules with only 24-hours notice need to be made via telephone/leaving a voicemail. The client understands that if the client does not provide a minimum notice of 24-hours (CX/RS< 24 hr) or the client no shows (NS) for an appt. without a valid excuse, the client's credit card on file will be charged $60 for the first offense and the full session fee for every missed appt. thereafter. If this happens more than twice, JW reserves the right to terminate the therapeutic relationship and will provide referrals to other appropriate clinicians and the client will be responsible for paying the resulting fees for the offending NS/RS/CX. For clarification, a "valid excuse" would be if there was an act of nature/God preventing the client's arrival (i.e. a communicable illness for which the client was unable to call ahead of time to inform JW of the illness; if the client were hospitalized or otherwise medically incapacitated; if the

client were involved in an emergency, or if any of these things happened to a close family member that the client takes care of and the client was unable to contact JW due to the circumstances). The client understands that EAP &/or Ins. Co. cannot/will not be billed for CX/RS< 24 hr &/or NS therefore the client is fully responsible for the payment.

About Methods of Communication & Protection of Privacy
My initials indicate that I consent to communicate with JW using the following methods (initial the box beside the method(s) you consent to use for communication with JW):

- Telephone: JW maintains a confidential voice mail associated with her office phone (352-514-2562). JW strongly recommends that clients utilize telephone communication as the primary mode of communication with JW for the purposes of scheduling appointments and/or holding *brief and infrequent* discussions regarding treatment (see section entitled About Fees & Payments for information related to fees for outside of session contacts initiated by the client).
- Fax: JW maintains a secure communication system via fax (561-784-6999). JW may utilize this system in order to bill the client's insurance and send treatment-related documents (per client request with a signed release of information).
- Email: JW utilizes two different email systems for the purpose of communicating with clients: 1) Gmail, which is not encrypted or HIPPA-compliant and 2) a secure, encrypted, and password protected email system through TherapyAppointment.com. **If the client chooses to communicate with JW via email, JW hereby advises the client to utilize the secure, encrypted, and password protected email system through TherapyAppointment.com as opposed to Gmail**. Note that this system will require the client to select a user name and password in order to retrieve messages from JW. Should the client choose to communicate with JW through Gmail, note that JW cannot guarantee the confidentiality of any information sent by the client to JW's Gmail account, nor can JW guarantee the confidentiality of any information sent by JW to the client's general, unencrypted email account (i.e. Yahoo, AOL, Hotmail, etc.). **Also note, all email communications are considered a part of the client's clinical record and, thus, subject to all privacy regulations and limitations as discussed in the HIPPA Notice of Privacy Practices**.
- Text: Should the client choose to communicate with JW via text, note that JW cannot guarantee the confidentiality of any information exchanged between the client and JW. The client may choose to have JW send automated appointment reminders to their cell phones, as per the Appointment Reminders and Online Appointment Scheduling agreement; however, the client acknowledges that communication via text is not confidential and/or HIPPA-compliant and JW cannot guarantee the confidentiality of any information sent via text. **Also note, all communications via text are considered a part of the client's clinical record and, thus, subject to all privacy regulations and limitations as discussed in the HIPPA Notice of Privacy Practices.**

About Social Networking & Use of Search Engines

- Social Networking Sites: JW does not accept "friend" requests from current or former clients on social networking sites, such as Facebook due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, JW requests that clients do not communicate with her via any interactive or social networking web sites.
- Google/Search Engines: At times JW may conduct a web search on her clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss it with JW immediately.

About the Therapist's Responsibilities & Client's Responsibilities
Jamie F. Wintz, LMHC, LLC is responsible for:

- billing for services provided to the appropriate, designated party (i.e. EAP and/or Ins. Co. or directly to the client if the charge is not an Ins. billable item) and explaining any charges as necessary;
- going over the client's goals, symptoms, &/or diagnosis with clients and suggesting various types of treatment;
- explaining the advantages & risks of therapy as necessary/appropriate;
- ensuring that another licensed therapist will be made available to the client via telephone in the event of a client having an urgent need when JW goes on vacation or has some type of other situation in which she'd be unreachable or unavailable for more than 24-hours;
- adhering to all state & federal laws pertaining to the practice of mental health counseling services;
- adhering to all codes of ethics of any professional association the therapist is involved with;
- keeping scheduled appointments with clients unless there is an unforeseen emergency – in which case clients will be informed as soon possible;
- informing clients in writing if there are to be any changes to this agreement.

The Client's Responsibilities are to:

- understand EAP &/or mental health Ins. benefits (i.e. deductible, co-pay, co-insurance, authorization requirements, etc.) & to notify JW of any changes to the client's benefits as soon as the client is aware of such changes;
- pay for services not covered by the client's EAP and/or Ins. Co. unless restricted by contract;
- notify JW of any changes to the client's address, phone number(s), medical conditions, medications, employment, symptoms & credit card information;
- be on time to the client's appts. & to call JW if running behind; <u>Clients must pay the full session fee/copay even if tardy.</u>
- schedule appts. with full intention of keeping them regardless of the client's right to CX or RS within 24-hours;
- give JW as much notice as possible if the client's appointment needs to be CX or RS and understand that the 24 hr. notice is the minimally acceptable amount of time to give unless there are "valid excuses;"
- leave the client's name, an acceptable phone number to call back (&/or leave a message at) and the reason for the message so JW can get back to the client. JW is not responsible for returning inaudible messages – so please speak slowly and clearly and leave the number twice. When messages are inaudible, JW cannot return the calls;
- reserve contact with JW outside of session for urgent issues or scheduling purposes only (non-urgent issues should be journaled & presented at the next scheduled session);
- **understand JW is NOT an emergency or crisis treatment provider. If the client has an urgent situation that arises, the client will leave a brief but detailed message & can expect a call within 12 hours (JW will always attempt to respond to the client as soon as is possible);**
    - call 911 (not JW) if having a life threatening emergency (or if appropriate the client can go to the nearest Emergency Room);
    - call the Mobile Crisis Unit (not JW) at 561-383-5777 if you are not sure whether you should go to the Emergency Room;
    - understand that JW reserves the right to refer the client for appropriate mental health services in the community should it become evident that the client requires a level of care greater than JW is able to provide in an outpatient setting.
- **be responsible for and active in treatment**;
- understand that no other professional sharing office space with JW or that is otherwise in affiliation with JW will be held responsible for any aspect of the client's on-going treatment;
- come up with a treatment plan/goals with JW that address the symptoms of the client's mental health condition that is making counseling "medically necessary". These goals must be measurable & objective (behaviorally based) & will need to be reviewed regularly;
- allow for/complete assessments on a regular basis as required to monitor my mental health condition to ensure that treatment is still required and is appropriate;
- ask questions if not understanding the treatment plan or any aspect of treatment;
- **understand that therapy does not guarantee resolution of circumstances/problems/issues (i.e.- couples counseling does not guarantee that the couple's relationship will be saved);**
- **understand that therapy can run the risk at times of creating uncomfortable feelings & can even sometimes worsen symptoms/circumstances as sometimes change does (i.e. – discussing past traumatic situations can elicit painful feelings on the way to feeling relief);**
- communicate with JW if expected changes are not being seen or felt within a reasonable amount of time. Typical therapy can last anywhere from 3 sessions to over 6 months depending on the severity and complexity of the symptoms/issues;
- inform JW if there is any possibility that the client may become involved in a legal situation in which the client's therapy could be implicated;
- **understand that JW is not an expert witness under any circumstances, is not a custody evaluator, does not make fitness for duty or disability determinations of any kind, & does not appear in court unless subpoenaed by a Judge. As such JW will not provide records or testimony unless compelled to do so by a subpoena. JW will generally not write or sign letters, reports, declarations, or affidavits to be used in any of the above matters nor communicate with attorneys;**
- **understand that it is therefore agreed that should there be legal or disability type proceedings neither the client, nor the client's attorney, nor anyone else acting on the client's (collective of those signing) behalf will call on JW to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested;**

- communicate with JW about the desire to terminate therapy & to discuss with JW questions or disagreements about the therapy process. The client agrees, at minimum, to a closing phone call but understands the best way to properly terminate a therapeutic relationship is by all therapeutic participants to engage in a closing session;
- understand JW (when done ethically and legally) may terminate therapy at any time with any client;
- **understand that if there are no future appts. booked & there has been no contact between the client & JW for a period of 30 days or more that the client's case will be considered closed. The client will receive a letter by mail prior to the case being closed. Should the client desire for the client's case to be reopened, the client will need to reestablish contact with JW**;
- ensure that the minor's or vulnerable adults involved in therapy with JW understand this contract in full.

Acknowledgement of/Agreement to Informed Consent for Treatment
The undersigned/the client has had the opportunity to ask any questions that the client may have about this informed consent. By signing this informed consent the client is agreeing to adhere to all of its contents and is voluntarily choosing to enter into a therapeutic relationship with Jamie F. Wintz, LMHC, LLC and may terminate services at any time.

___________________________	___________	____________________		______
Adult Client Name	Date of Birth	Signature		Date
_________________________	__________	__________________	_________________	______
Vulnerable Adult/Minor Client Name	Date of Birth	Guardian Signature	Relationship to client	Date

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Health Insurance Portability and Accountability Act ("HIPAA")
Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the American Mental Health Counselor's Association (AMHCA) Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- *For Treatment.* Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.
- *For Payment*. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.
- *For Health Care Operations.* We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.
- *Required by Law*. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.
- *Without Authorization*. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. **As a mental health counselor licensed in the state of Florida and as a member of the AMHCA, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the AMHCA's Code of Ethics and as well as HIPAA.**
    - *Child, Vulnerable Adult or Elderly Abuse, Neglect, or Exploitation*. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child, vulnerable adult, or elderly abuse, neglect or exploitation and/or the suspicion of such. If you are a minor child, or if you have a legal guardian assigned to your care, your parent or legal guardian may also be informed as required by law.
    - *Judicial and Administrative Proceedings.* We may disclose your PHI pursuant to a subpoena (with your written consent or without your consent if it is a judge's subpoena), court order, administrative order or similar process.
    - *Deceased Patients*. We may disclose PHI regarding deceased patients as mandated by state law or to a family member or friend that was involved in your care or for payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased

person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
    - *Medical Emergencies*. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
    - *Family Involvement in Care*. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
    - *Health Oversight*. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
    - *Law Enforcement*. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
    - *Specialized Government Functions*. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
    - *Public Health*. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
    - *Public Safety*. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- *Research*. PHI may only be disclosed after a special approval process or with your authorization.
- *Fundraising*. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.
- *Verbal Permission*. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
- *With Authorization*. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI*

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Jamie F. Wintz, LMHC, LLC, 8259 N. Military Trail, Suite 14, Palm Beach Gardens, FL 33410.

- *Right of Access to Inspect and Copy*. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person. If you ask me to send a copy of my records about you to someone else such as another doctor or even to you, I will do so as quickly as I can and it will never take longer than thirty days after you sign the Authorization form for the records.
- *Right to Amend*. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- *Right to an Accounting of Disclosures*. You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- *Right to Request Restrictions*. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- *Right to Request Confidential Communication*. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- *Breach Notification*. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- *Right to a Copy of this Notice*. You have the right to a copy of this notice.

*This practice does keep some psychotherapy notes which require a written, specialized and separate authorization for release of information. Psychotherapy notes are separate from your medical record and are not ever made accessible to insurance or EAP companies.

*Please understand that if you have been seen with any other person during your treatment with me, your record is no longer just your own, it is considered a conjoint file. Therefore, in order to provide a copy of the record to you or to anyone, I will need a release of information procured from each individual that attended your treatment as per Florida Statue § 491.0147(2).

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Jamie F. Wintz, LMHC, LLC, 8259 N. Military Trail, Suite 14, Palm Beach Gardens, FL 33410 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is September 2013.

Client name:_____________________________ DOB: ________________ SSN: __________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Jamie F. Wintz, LMHC, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Jamie F. Wintz, LMHC, LLC at (352) 514-2562.

______________________	__________	______________________		_______
Adult Client Name	Date of Birth	Signature		Date
______________________	__________	______________________	____________	_______
Vulnerable Adult/Minor Client Name	Date of Birth	Guardian Signature	Relationship to client	Date

☐ Client or Guardian refuses to Acknowledge Receipt: ______________________ __________

Therapist's Signature Date

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Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.JamieWintz.com** and click "Appointments" to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Client's name: ____

Requested login name: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
(Up to 15 letters or numbers only. No spaces.)

Requested password: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
(Up to 10 letters or numbers only. No spaces.)

Your email address: ____

Your cell phone number: ____

Your cell phone carrier (circle one):

Alltel	AT&T	Boost Mobile	Nextel	Sprint	SunCom
T-mobile	Verizon	VoiceStream	Virgin Mobile	(Other) ______________	

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my cell phone

_____ None of the above. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Additionally, by signing below, I acknowledge that:

- Information sent by Jamie F. Wintz, LMHC, LLC can be intercepted by people other than me but that I accept this risks as self-evident (i.e. someone opens my mail, hacks my or the therapist's email or cell, reads my text message, etc.).
- Emails, cell phones, and Wii-Fi connections can be unsecured/unencrypted forms of communication – engaging with Jamie F. Wintz, LMHC, LLC over these types of technologies puts my/our communications at risk.
- I am responsible for keeping my information updated with Jamie F. Wintz, LMHC, LLC at all times to avoid unintended disclosure of PHI (i.e. a change in phone number or address).
- I can withdrawal/change my mind about these preferences in writing to Jamie F. Wintz, LMHC, LLC at any time.

--   -------------------------
Adult Client/Guardian's Signature   Date

Jamie F. Wintz, LMHC, LLC
Psychotherapist

8259 N. Military Tr. Suite 14, Palm Beach Gardens, FL 33410

tel. 352-514-2562
fax. 561-784-6999
Therapist@JamieWintz.com
www.jamiewintz.com

CREDIT CARD ON FILE AGREEMENT

Jamie F. Wintz, LMHC, LLC has implemented a new policy which requires all clients to keep a credit card on file for payment purposes. We have a new system which enables us to maintain your Credit Card information securely on file and which can only be accessed under the terms you specify below.

By providing us with your credit card information, you are giving Jamie F. Wintz, LMHC, LLC permission to automatically charge your credit card on a weekly, monthly, or as needed basis (if payment is not made by you within 30 days of an invoice) for the amounts due for services received. These amounts match the patient's responsibility amounts as determined by your insurance company or self-pay agreement and are reflected on the explanation of benefits (EOB's) from your insurance company or invoice from the therapist.

As noted in the Informed Consent, any canceled or missed appointments without 24-hour notice will result in the credit card on file being charged the cancellation/no show fee of $60.00 for the first offense and the full session fee for every missed appointment thereafter.

If the credit card information we have on file changes for any reason, you must notify Jamie F. Wintz, LMHC, LLC as soon as possible. If you have any questions about a charge please notify us within 15 days. After 30 days all charges will be assumed to be correct.

We will maintain clear record of all payments and charges. However, in the rare case that an overpayment occurs, your account will be credited on the upcoming invoice or if the balance is zero and you have taken a break from therapy a reimbursement can be put back on the same credit card. A receipt will be sent to you from Merchant Warehouse (our credit card processing company). You will also receive a paid invoice from Jamie F. Wintz, LMHC, LLC showing your payment.

In the event of a declined charge, you will be asked for a new credit card number and/or payment before continuing treatments.

I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE JAMIE F. WINTZ, LMHC, LLC TO CHARGE MY CREDIT CARD AS STATED ABOVE.

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover CARD NUMBER: ____

Exp. Date: ______ / ____ Security Code or CID #: _____________________ Billing Zip: _______________

Name on Card: _________________________ Client's Name: ____

Email address that you would like receipts sent to: ____

Billing Address on Card (if different from our records): ____

City: ___________________________________ Zip: _________________________________

Signature: ____ Date: ________________________

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SYMPTOMS CHECKLIST
(clients under the age of 18 years)

CLIENT NAME: ________________________________ **DATE:** _________________

Form completed by: ______________________ **Relationship to client:** ___________________

REASON(S) FOR COMING TO THERAPY:

____

____

Problems have persisted for:
□ less than 1 week □ 1 to 4 weeks
□ 1 week to 3 months □ 3 to 6 months
□ 6 to 12 months □ 1 to 2 years
□ chronic

Check all **current** problems/symptoms of the **client** receiving services:

□ guilt	□ poor concentration	□ bedwetting
□ crying spells	□ distractibility	□ wetting self during the day
□ nightmares	□ poor memory	□ problems with bowel movements/soiling pants
□ irritability	□ disorganized thoughts/beliefs	□ medical illness
□ grief	□ odd thoughts/beliefs	□ poor grooming/poor hygiene
□ depressed mood	□ paranoid	□ self-injurious behaviors
□ fatigue/low energy	□ out of touch with reality	□ bingeing/purging /bulimia
□ hyperactive	□ obsessions	□ hypochondriac/imagined sickness
□ mood swings	□ repetitive behaviors	□ laxative/diuretic abuse
□ dramatic	□ panic attacks	□ anorexia/self-starvation
□ feelings of worthlessness	□ sexual issues	□ significant weight gain or loss
□ feelings of hopelessness	□ problems with attention	□ increase/decrease in appetite
□ low self-esteem	□ oppositional/non-compliant	□ nausea/feel sick
□ nervousness	□ aggressive behaviors	□ headaches
□ avoidant behavior	□ fighting (physical)	□ stomachaches
□ anxiety	□ arguing (verbal)	□ vomiting
□ social withdrawal/isolation	□ excessive anger	□ constipation
□ fidgety	□ property destruction	□ diarrhea
□ sexual abuse victim	□ work problems	□ problems getting to sleep
□ physical abuse victim	□ substance/alcohol use/abuse	□ problems staying asleep
□ emotional abuse victim	□ legal problems	□ problems waking up
□ sexually abuses others	□ marital/family/relationship crisis	
□ physically abuses others	□ poor peer relationships	□ thoughts of suicide (killing self)
□ emotionally abuses others	□ poor impulse control	□ thoughts of homicide (killing someone else)
□ hallucinations (sees, hears, feels things that others do not)		□ suicide attempt(s)

□ excessive fears of ____ □ agoraphobia (difficulty leaving house)

□ behavior problems at home –Describe: ____
□ irresponsible behaviors- Describe: ____
□ School Issues: □ academic problems □ behavior/conduct problems □ excessive absence □ tardiness
□ skipping school □ refusing to attend school □ suspensions □ referrals
□ Other: _____________________________________

List all persons currently living in client's household:

Name	Age	Relationship to client
1. _______________________________	_____	___________________________
2. _______________________________	_____	___________________________
3. _______________________________	_____	___________________________
4. _______________________________	_____	___________________________
5. _______________________________	_____	___________________________
6. _______________________________	_____	___________________________
7. _______________________________	_____	___________________________

Parent/Guardian's Signature _________________________________ Date ____________

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Parental Consent for Counseling a Minor

(Form to be completed by the divorced/separated/otherwise shared custody parent of a child receiving therapy services.)

I, ________________________________, am aware that my child, ______________________________, has an intake
(divorced/separated/otherwise shared custody parent's name) (child's name)

appointment scheduled with Jamie Wintz on _______________________ at __________. The appointment was made
(date of intake appt.) (time of intake appt.)

by ________________________. By my signature below, I acknowledge that my child will be in continued
(name of parent initiating the intake appt.)

counseling with Jamie Wintz and give my consent for Jamie Wintz to provide counseling services to my child. By my signature below, I also acknowledge that there are limits to what a therapist can share with a parent with respect to a child's right to confidentiality (as listed in the HIPPA Notice of Privacy Practices and Informed Consent Forms available on http://www.JamieWintz.com). Lastly, by my signature below, I acknowledge that I am bound by all service terms and conditions as outlined in the HIPPA Notice of Privacy Practices and Informed Consent Forms.

____ _______________________

Parent's signature Date

____

Parent's printed name

(Please check the box and sign below ONLY if the following statement applies within your family)

☐ My child's mother/father has had his/her parental rights legally terminated by a court of law and thus, does not have contact with my son/daughter. I understand that I am required to provide the Therapist legal documentation supporting this claim within 30 days of my child's initial appointment.

___________________________ ___________________________

Parent's signature Date