100 Executive Way, Suite 200
Ponte Vedra Beach, Fl 32082
Phone: (904) 280-8006

I'm glad you are here. You are probably anxious to talk about the reasons why you are coming to therapy. The document below contains important information about our professional services and business policies. Please sign at the bottom. All the forms you are signing today (and some more good information) are on my website. **www.sabrinabowen.com**

Client (s) name (s):_____

Date of birth:_____

If Client is a minor, parents' names: _____

Address:_____

Please circle your preferred way for us to contact you/send reminder messages: email, text, phone call.

Cell number:_____Home phone number:_____Email:_____

How did you hear about us? _____

Reason for coming today:_____

If you are here for Couple, Co-joint or Family Therapy, please write the name of others who will participate in therapy.

_____

Are you taking any medications? If yes, please list name and dosage:

_____

_____

Any allergies?_____

Any health issues? _____

Who is your primary care physician? _____ phone number: _____

Any family history or personal history of (please circle): alcohol use, substance use, sexual abuse, trauma, physical abuse, domestic violence, emotional abuse.

Insurance Information:

Insured's Name:_____ date of birth of insured:_____

Relationship to client:_____ Name of insurance Company:_____

Policy or ID #:_____ group #:_____

Insured is employed by:_____ Please inform us immediately of any changes in insurance.

All people participating in therapy need to read and sign the form below.

Consent Form: Please read and sign:

Office Information/Emergency Procedures
In case of a life-threatening circumstance or emergency, please call 911 or a crisis hotline.
If you need to reach me to share some information you can leave me a message on my private confidential voice mail. I do not return phone calls unless it is an urgent matter. As a general rule clinical issues should wait until your next appointment.

General Information about Therapy
The counseling process involves working together with the therapist to achieve a desirable outcome. The treatment plan will be based on the goals of therapy.
If we do not have a face-to-face meeting for a period longer than 45 days therapy will be considered terminated. If at a later date you desire to return to therapy, you are welcome to call to request a new appointment.
All information shared within the therapist–client relationship is kept confidential, unless written permission is obtained. There are certain limitations to confidentiality. The therapist is legally bound to break confidentiality in instances of child abuse, elder abuse, and other instances of potential harm to self or others. Also, confidentiality can be broken with a court order. If you use a 3rd party payer (e.g insurance) they will have access to most, if not all, of your records. Please see the Notice of Privacy Practices.
If applicable, as a parent, guardian, or custodian of _____minor child(ren), I/we hereby give permission/consent for the minor children to participate in therapy. Florida law does not guarantee confidentiality of children; however, therapy goes better if we are able to keep most issues confidential. As a rule, I will communicate generally about your child's treatment.

When I agree to treat a couple or a family, I consider that couple or family to be the client/patient (one single file). At times I may see a smaller part of the treatment unit (e.g., a partner) for one or more sessions. These sessions should be seen as part of the work with the larger unit (e.g. couple or family). Also, information learned in an individual session (or smaller family unit) may be shared in order to effectively serve the couple/family being treated. That is, I will use my clinical judgment as to whether, when and what to disclose. In cases where the client is the "couple" either partner can have access to the records. Alternatively, if this smaller unit (e.g., one partner of a couple) wants to discuss issues that they do not want shared with the other family member/partner, a referral to an individual therapist who is not treating the family or couple can be made.

***Email/ Audio/Recordings:** If you decide to communicate via email with us, please realize that confidentiality cannot be promised due to the nature of the internet. I will not communicate via email regarding clinical issues. Instead, these issues will be addressed in the next session. By writing your email address here _____ you authorize me, Sabrina Bowen, LMFT (and any of my staff) to email you. Please understand that email is not secure and there is a risk that these emails could be read by a third party. By signing below, you agree that you will not record the sessions either in audio or video format without the therapist's written consent. I agree also not to record you (audio or video) without your written consent.

Fees:
Each session costs $150. When you book an appointment, you are paying to have that time reserved for you. A minimum of 24-hour notice is required to reschedule or cancel an appointment. Usually a reminder call is done as a courtesy to you. **A fee of $150 will be charged for sessions canceled without 24-hour notice whether you received a reminder call or not. Monday appointments need to be canceled by Friday.**
Fees for letter writing and phone calls are also charged according to the above hourly rate. We do not allow for unpaid balances, but in the rare case where there is one, payment not received by the due date will be billed an additional $25 for each month that the bill remains unpaid. I normally do not accept insurance benefits, but I may be required to do so in connection with some managed care contracts. If I am a provider with your

plan, you are responsible for any payments not covered by your insurance or other third-party payer, including co-pay, deductibles, out of network deductibles, non- covered services and denial of service fees. Payment of co-pays is made at the time the service is provided. It is recommended that you call your insurance before our session to know your co-pay. If I am not a provider for your plan and you have a mental health diagnosis you will pay the full fee at the session and I will give you an invoice that you can seek reimbursement from your plan.

I do not testify in court. In the event disclosure of your records or the therapist's testimony are required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by me at the time of the request or service of the subpoena (current rate is $350 per hour). The charges will include the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made 10 days to the services rendered by me. I will require a deposit for anticipated court appearances and preparation.

Disclaimer: At times I refer clients to other professionals. Although I take my referrals seriously and want you to get the best care, I am not responsible for the care received from professionals I refer you to. **Notice of Privacy Practices** The Health Insurance Portability and Accountability Act of 1996 grants you the right to expect privacy of health records. We have a Privacy Practices Policy. We encourage you to read it and ask Sabrina Bowen any question you may have. You can request a copy of the Privacy Practice at any time. It's also posted on www.sabrinabowen.com. When we treat you we obtain certain information to process appropriate treatment or payment. All or part of this information may need to be shared with others (e.g. Insurance). By signing below you acknowledge that you have been given a copy of the Privacy Practice and you authorize us to submit information as necessary.

Consent to Treatment

By signing below you are stating that: "I have read and understood the Informed Consent Form. I have been given the opportunity to ask questions to my satisfaction. By signing I agree and accept the above policies. I authorize payment of benefits from any 3rd party (e.g. Insurance) to my provider. I understand that using insurance decreases my confidentiality. I understand that I will be given an appropriate mental health diagnosis if I choose to use my insurance".

_____ (print name) _____ (signature)

_____ (print name) _____ (signature)

Date: _____

Sabrina Bowen, M.S., L.M.F.T._____ (signature)

Thank you!