Thrive Therapy
2734 Oak Ridge Court, Unit 404
Fort Myers, FL 33901
239-963-4367

OFFICE POLICIES AND GENERAL INFORMATION

Welcome to our office. We look forward to working with you. Please be sure to read carefully and sign the following intake documents prior to your first session. The completion of these forms will make it so that we can utilize our time wisely by beginning to address your presenting concerns and enabling us to best help you and/or your family. During your first visit the intake documents will be reviewed with you and any questions or concerns regarding them will be addressed. A valid proof of id and insurance card (if applicable) are required to complete your registration.

Initial and Future Sessions
The initial session consists of a 60 minute biopsychosocial assessment where you and your therapist will discuss personal background information and presenting concerns. Upon completion of the assessment, your therapist will advise you as to the appropriate plan of care. Future sessions are scheduled at the time of the initial session and/or via telephone contact. Our goal is to serve you at your designated appointment time and we request that you be prompt for your appointment. Sessions begins promptly at the scheduled appointment time regardless of your time of arrival. Individual sessions are held for 50 minutes. Family and/or group sessions are held for an hour and 30 minutes. Please be aware that a child's caregiver needs to be present during the entire session in case of an emergency. Please be advised that photography and video recordings are not permitted. In addition, therapists do not accept gifts of any kind. No weapons, drugs, or alcohol will be permitted in or around Thrive Therapy's premises. Any individual carrying a weapon, appearing intoxicated or under the influence of substances will be reported to the authorities and will be asked to leave the premises.

Hours of Operation
Please be advised that our office is open Monday-Friday 9:00am-5:00pm. A limited number of flexible appointment times are available in the evening per request.

Cancellation/No-Show Policy
If it is necessary for you to cancel an appointment, a notice of **48 business hours** is required prior to the scheduled appointment day and time or the usual fee for services will be charged on the scheduled day of your appointment via your credit card on file. In the case that insurance covers the cost of therapy and you miss your appointment, you will still be charged the cancellation fee at the full rate of session. Insurance does not pay for missed appointments and it is the client's financial responsibility. In the case of inclement weather and/or illness of the therapist, the therapist will notify you by telephone prior to the scheduled session of the cancelation. Otherwise, all sessions will continue as scheduled. If you cancel two consecutive times you will be at risk of losing your designated time slot for your appointments. If you do not show for your appointment you will be charged the day of your missed appointment via your credit card on file.

Telephone and Electronic Communication
If it is necessary for you to speak to your therapist in between your scheduled appointments, please leave a message on the voice mail if your therapist is unable to answer your phone call. Your call will be returned within a 24 hour period. No telephone calls will be taken by therapists past 6:00pm Monday-Friday or on Saturday and Sunday. As a reminder, therapists are not available when in session with other clients. Telephone calls lasting more than 5 minutes will be subject to a telephone counseling session fee at a rate of $35 per 15 minutes. If you would need to speak to your therapist for longer than 5 minutes, it is recommended that you schedule in advance an in-person appointment or a telephone consultation to address your concerns.

Thrive Therapy does not accept text messaging as a form of communication for scheduling, canceling or addressing your questions or concerns. Please be advised that if you should submit a text message to Thrive Therapy's phone line we cannot guarantee the confidentiality of your message.

With access to your therapist's email address, please be advised that the preferred means of contact is through telephone. Email communication should be limited to brief exchanges about scheduling and payment issues. If emails are detailed and go beyond brief exchanges about scheduling and payment issues and your questions or concerns, an electronic counseling session fee will be charged at a rate of $35 per exchange. Please be advised that Thrive Therapy takes security measures to protect your confidentiality. However, due to the electronic nature of the communication it cannot be guaranteed.

Should your therapist deem e-counseling sessions appropriate, please be advised of the limits to confidentiality. E-counseling sessions would be provided at the same rate as an individual therapy session. All office policies also apply to e-counseling.

Social Media Policy
We strive to protect your confidentiality and keep the therapeutic relationship boundaries clear. Therefore, we cannot accept friend or connection requests from clients on any social media platform (Facebook, LinkedIn, Twitter, etc.). You may follow Thrive Therapy social media accounts that are open to the public but ask that you do not comment or in any way identify yourself as a current or former client. If done so, all comments will be deleted to protect privacy and confidentiality.

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Limitations of Services and Confidentiality
We offer outpatient psychotherapy, consultation, supervised visitation, and educational services only. This practice is not geared to aid in the case of an emergency. We do not accept after hours telephone or electronic communication. Should you require emergency services after hours, please call 911 or go to your nearest hospital. For after hours mental health resources in Lee County call SalusCare at 239-275-3222 or in Collier County call David Lawrence Center at 239-455-8500.

Please be aware that all of our therapists are mandated reporters in the State of Florida as indicated by Statute 39.201. This indicates that any disclosure of child or elder abuse during session will result in being reported immediately to the Florida Abuse Hotline at 1-866-96-ABUSE.

A time may present that you may casually run in to your therapist in public. It is our policy to ensure your confidentiality therefore we will not acknowledge or approach you for communication outside of the therapeutic setting.

We will not relay any information or contact any third party regarding you or your child's treatment without receiving a completed and signed release of information form prior to contact.

Separation/Divorce Policy
Thrive Therapy and its therapists are not custody evaluators and cannot make any recommendations on custody. We can refer you to a list of professionals who provide custody evaluations if needed.

For separated or divorced families, a court order regarding parenting responsibility and time sharing is required prior to the first initial session. If applicable, based on the court order or parenting plan, written consent from each parent is required prior to the first initial session. It is our goal to promote a healthy relationship between children and their parents. We recommend all parents or guardians, willing and able, to be involved in the therapeutic process, unless a court order prohibits it. The person who initiates the service or brings a child for the service is financially responsible. We will not bill another party unless a commitment to assume financial responsibility is provided in writing. Therapists remain neutral parties during the therapeutic process and do not form loyalty to one side over the other. The therapist's role is to provide therapeutic services and support for your child.

Court Attendance Policy
If a client is involved in a court proceeding and a request is made for information concerning the professional services a therapist has provided to them, such information is protected by the therapist-client privilege law as indicated by Statute 90.503. Clients are discouraged from having their therapist subpoenaed or having them provide records for the purpose of litigation due to the limited information that can be provided. If subpoenaed and needed in court, fees associated with any court proceedings are $200 for the first hour and $125 for every hour thereafter that the therapist is present. A court attendance agreement form must be reviewed, completed and signed 48 hours prior to the scheduled court appearance.

Financial Responsibilities
Please be advised that the fee for service is due at the time the service is rendered. Payments can be provided via cash, check, and/or credit card. We accept Visa, MasterCard and Discover. We do not accept American Express. Returned checks will be charged a $20 returned check fee. Returned checks must be picked up within three (3) business days and the full amount due must be paid in cash. If a check is returned for insufficient funds, we will require that you pay using cash or credit card for all further sessions. All credit card transactions will accrue a 2.77% convenience fee.

Session Times and Fees	
Biopsychosocial Assessment (60 minutes)	$150.00
Individual Therapy Session (50 minutes)	$125.00
Family Therapy Session (1 hour, 30 minutes)	$200.00
Couples Therapy Session (1 hour, 30 minutes)	$200.00
Telephone Consultations longer than 5 minutes will be billed per quarter hour	$35.00
Electronic Consultation (email) longer than 5 minutes will be billed per quarter hour	$35.00
Record review or preparation of any documents or forms, per quarter hour	$35.00
Court related work	$200.00 first hr. / $125 add. hr

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CLIENT RIGHTS AND RESPONSIBILITIES

As a client, you have the right:

- to receive quality services in a respectful manner without discrimination. Services are not restricted or denied based on age, sex, race, religious beliefs, ethnic origin, location of residence, marital status, physical or mental disability, heath status, or sexual orientation.
- To be assured freedom from neglect, abuse, exploitation, retaliation, humiliation, or any form of corporal punishment.
- to consent or refuse services before they are provided.
- to make an informed choice of services.
- to be educated regarding the counselors educational background; nature and purpose of services provided; risks and benefits of treatment; and your rights and responsibilities.
- be informed prior to any transfer or discharge form service.
- to know about charges for services.
- to refuse or discontinue services at any time.
- to receive services based on an individualized treatment plan.
- to voice an grievance regrading services. If you are dissatisfied with any aspect of your treatment, please raise your concern to your counselor.

As a client, you have the responsibility:

- to provide accurate and complete information regrading past and current health issues, medications, substance use, domestic violence and other circumstances that may impact your services or the services of your child.
- to remain in the building while your child is in session. Please do not drop off your child to do errands or something else during their appointment time. A parent needs to be present at all times in case of emergency.
- to keep your appointment. Please provide at least 48 business hours notice to change or cancel your session to refrain from being charged for the scheduled session.
- to refrain from attending session while under the influence of drugs and/or alcohol. Violators of this policy will be asked to leave, and law enforcement will be notified, if necessary.
- to sign the releases and consents necessary in order to determine and authorize treatment services accordingly.

As a therapist, we are required to:

- Provide quality and ethical therapeutic services.
- Maintain the privacy of your mental health information as required by law.
- Provide you with a notice of the practice's legal duties and privacy practices with respect to PHI.
- Abide by the terms of the Notice of Privacy and Office Policies.
- Notify you if we cannot accommodate a requested restriction or request.
- Reserve the right to change the privacy and office policies, as needed.

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NOTICE OF PRIVACY PRACTICES

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

I. **Uses and Disclosures for Treatment, Payment and Health Care Operations.**

I may use or disclose your **Protected Health Information (PHI)** for treatment, payment, and health care operations purposes with **your consent.** To help clarify these terms, here are some definitions:
PHI refers to information in your health record that could identify you.

Treatment, Payment and Health Care Operations

- ***Treatment*** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
- ***Payment*** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- ***Health Care Operations*** are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, case management and care coordination.
- ***Use*** applies only to activities within my office, clinic, practice group, etc., such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- ***Disclosure*** applies to activities outside of my office, clinic, practice group, etc., such as releasing, transferring, or providing access to information about you to other parties.

II. **Uses and Disclosures Requiring Authorization (consent)**

I may use or disclose PHI for purposes outside for treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosure. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes I have completed about our conversation during a private or group session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. **Uses and Disclosure with neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- ***Child Abuse:*** If I know or have reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.
- ***Adult and Domestic Abuse:*** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- ***Judicial or Administrative Proceedings:*** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that your are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- ***Serious Threat to Health or Safety:*** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

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ACKNOWLEDGMENT OF RECEIPT OF CLIENT RIGHTS AND RESPONSIBILITIES

I, _____ have received a copy of the **Client Rights and Responsibilities.**
Print (First Name) (Last Name)
I acknowledge that I have read and understand my rights and responsibilities, as outlined therein. I have been given the opportunity to ask questions which have been answered to my satisfaction.

_____ _____
Client Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICIES AND GENERAL INFORMATION

I, _____ have received a copy of the **Office Policies and General**
Print (First Name) (Last Name)
Information. I acknowledge that I have read and understand my rights and responsibilities, as outlined therein. I have been given the opportunity to ask questions which have been answered to my satisfaction.

_____ _____
Client Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of the **Notice of Privacy Practices.**
Print (First Name) (Last Name)
I acknowledge that I have read and understand the notice and my rights, as outlined therein. I have been given the opportunity to ask questions which have been answered to my satisfaction.

The purpose of this document is to acknowledge the Notice of Privacy Practices as required by Section 164.520 of the federal Health Insurance Policy and Accountability Act (HIPPA). By signing this form, you consent to the use and disclosure of your protected health information only for the purposes of treatment, payment, and health care operations. You have the rights to revoke this consent, in writing, except where i have already made disclosures based upon your prior consent. If you need assistance to make the request in writing, it will be provided to you.

_____ _____
Client Signature Date

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CONSENT FOR COUNSELING SERVICES

Client's Name: _____

Address: _____

_____

Phone Number: _____ **Email Address:** _____

Date of Birth: _____ **Social Security Number:** _____

In case of an emergency, who should we contact? Please list their name and number.

Emergency Contact Name: _____

Emergency Contact Number: _____

Relationship to Client: _____

I, the undersigned, voluntarily agree to participate in counseling services. I understand that these services may be in the form of individual, family or group therapy. I also understand that any information obtained will be held in the strictest of confidence, except as stipulated in Florida Statutes 39, 394, and the Health Insurance Portability and Privacy Act (HIPPA), as described in the Privacy Notice. I further understand that I can authorize the release of information by completing a written consent form.

I recognize that I have the right to withdraw from therapy at any time, without prejudice, which could void this consent for counseling. I understand that I will be given the opportunity to ask questions about the foregoing to my satisfaction. I have also been provided with a copy of the office policies and agree to abide by them.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

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GUARANTEE OF PAYMENT

Client's Name:_____

Name of Financially Responsible Party:_____

Employer Name:_____

Billing Address:_____

_____

Primary Therapist: _____
Fee per visit: $150.00 Assessment, $125.00 Individual Session, $200.00 Family Session, $200 Couples Session
Special Payment Arrangements:_____
Cancelation/No-Show Policy: 48 hours or two business days notice is required prior to scheduled appointment for all cancelations or the above service fee will be charged via my credit card on file below. _____
(please initial)

Credit Card Information:

_____ _____
Cardholder's Name (Please Print) Cardholder's Full Billing Address

_____ _____ _____
Credit Card Number Security Code Expiration Date

This practice cannot provide loan or credit services. Therefore, we require payment at the time of service. I authorize Thrive Therapy, LLC to charge any visit or service for which I do not pay directly by cash or check to my credit card listed above. All credit card transactions will accrue a 2.77% convenience fee. I understand and agree that if Thrive Therapy, LLC is a participating provider in my insurance plan they may charge my credit card or debit card in the event (1) my insurance carrier fails to pay within 30 days of filing (as required by State law), and (2) I have been notified by letter or phone, and (3) I have been allowed to pay my bill within 10 days, and (4) I have failed to pay within those 10 days. This guarantee of payment is valid for twelve consecutive months after my last visit unless I cancel this authorization through written notice to Thrive Therapy, LLC.

_____ _____
Client/Responsible Parties's Signature Date

_____ _____
Therapist Signature Date

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CURRENT SYMPTOM CHECKLIST

Please check any of the following symptoms which you have recently experienced.

( ) trouble falling asleep
( ) sleep that is restless or disturbed
( ) waking up early and being unable to go to sleep
( ) sleeping too much
( ) feeling guilty
( ) depressive feelings that are worse in morning
( ) thoughts of ending your life
( ) having made suicide attempts
( ) self-injury behavior such as cutting, burning, head banging, biting, etc.
( ) fatigue or loss of energy
( ) poor concentration and memory
( ) decreased sex drive
( ) significant feelings of restlessness
( ) loss of pleasure in usual activities
( ) feeling worthless
( ) appetite loss
( ) weight loss
( ) weight gain
( ) feelings of sadness or depression
( ) withdrawing from others
( ) crying easily
( ) dramatic changes in mood
( ) decreased need for sleep
( ) excessive energy
( ) heart pounding or racing
( ) feeling fearful
( ) nausea or upset stomach
( ) spells of terror or panic
( ) pains in heart or chest
( ) shortness of breath
( ) nervousness or shakiness inside
( ) frequent urination and/or bed wetting
( ) recurrent nightmares
( ) repeated unpleasant thoughts
( ) drinking too much
( ) using/abusing drugs
( ) aggression towards other
( ) defiant behaviors
( ) poor boundaries
( ) panic attacks
( ) afraid of losing control
( ) having to repeat the same actions such as touching, counting, washing
( ) feeling uneasy in crowds (shopping, movies)
( ) having to avoid certain things, places, or activities because they frighten you
( ) feeling anxious when driving
( ) feeling very stressed, anxious or depressed because of a life situation
( ) engage in self-stimulation such as body rocking, hand flapping, thumb sucking, masturbation, etc
( ) being argumentative with others
( ) feeling critical of others
( ) feeling people dislike you
( ) feeling shy or uneasy
( ) hearing voices others do not hear
( ) seeing things others do not see
( ) wanting to be alone often
( ) feeling bored with others
( ) difficulty saying what you really think or feel
( ) feeling inadequate, less than others
( ) others do not understand you
( ) feeling lonely even when you are with others
( ) others not meeting your needs
( ) temper outbursts you could not control
( ) other relational problems
( ) marital problems
( ) death of a relative, friend or pet
( ) financial problems
( ) legal problems
( ) victim of sexual abuse
( ) victim of physical abuse
( ) victim of emotional abuse