

**WELCOME!**

# Congratulations!

The hardest step with counseling is making the first appointment and you did it! Here are a few recommendations to keep your momentum so you can maximize your benefits from coaching or counseling:

**Financial Concerns:** If there are any financial issues or concerns we may be able to work with you on this.

**Calendar:** Always remember to have your calendar when you come to TLC and when you call to reschedule:

**Save time:** Having your calendar will save you time and keep you from needing to remember to call us back

**Life gets busy:** Often people forget to call back to reschedule or schedule a follow-up appointment

**Consistency:** Follow-up appointments are important in order to receive the maximum benefits from your first session!

**Canceling or rescheduling:** If you do not receive a reminder call please keep in mind the reminder is a courtesy but we need to leave it up to you to contact us at least two (2) business day prior to your appointment time if you need to reschedule

**Expectations:** Everyone has their own idea of what to expect from counseling varying from watching Dr. Phil or prior experiences. Please discuss your feelings if you feel your expectations are not being met. We can usually address this concern right away.

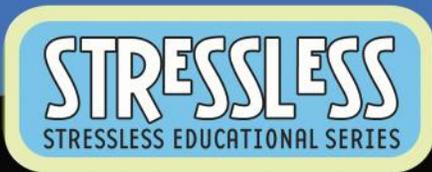
**Closure:** When things are going well often clients cancel their appointment before letting us know about their progress. We love to hear the good news so it's very



**Directions:**  
For directions to our location, please download the maps at [totallifecounseling.com/maps](http://totallifecounseling.com/maps)

**Bring Forms:**  
Please remember to print out your new client registration forms and fill them out prior to your first session. Download the forms @ [totallifecounseling.com/forms](http://totallifecounseling.com/forms)

Should you need further assistance or an emergency arises before we can meet, please feel free to call 407-248-0030



[StressLessSeries.com](http://StressLessSeries.com)



[TotalLifeCounseling.com](http://TotalLifeCounseling.com)



**Patient Information Forms**

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent/Guardian Information**

Parent/ Guardian Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Place of Employment \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: Single Engaged Married How Long \_\_\_\_\_? Divorced How Long \_\_\_\_\_? Widowed How Long \_\_\_\_\_?

Name of Person or Establishment who referred you \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_

*I would like to be added to Total Life Counseling Newsletter to receive free articles, tips and resources:*  Yes  No

*I hereby give Total Life Counseling Center permission to provide counseling services for the patient mentioned above: Signature of parent or legal guardian:*

*Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

Patient's DOB: \_\_\_\_\_ Age: \_\_\_\_\_ School \_\_\_\_\_ Grade: \_\_\_\_\_

Has patient received counseling from a Pastor, Psychiatrist, or other counselor?  Yes or  No

If yes, Who: \_\_\_\_\_ When: \_\_\_\_\_

What was the previous chief complaint or diagnosis: \_\_\_\_\_

Has anyone in your family been treated for a mental disorder?  Yes or  No

If yes, Who & What were they treated for? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Significant past medical conditions and years \_\_\_\_\_

Current medical conditions (include any known allergies or dietary concerns) \_\_\_\_\_

Medications/dosage patient is currently taking and for what reason: \_\_\_\_\_

Briefly describe major reasons for coming to counseling and what you hope to accomplish: \_\_\_\_\_

Severity of Problem:  Crisis  Severe  Moderate  Mild

I prefer to be  texted  emailed  phone call  none for appointment reminders.

I would like to be added to Total Life Counseling Newsletter to receive free articles, tips and resources:  Yes  No



<b>Child/Adolescent Comprehensive Psychosocial Assessment</b>						<b>Staff Notes</b>
<b>Family Information:</b>						_____
Family	Name	Age	Educ.	Occup.	At Home	
Dad						
Mom						
Stepdad						
Stepmom						
Bro/Sis						
" "						
" "						
Other						
Has your child ever lived with anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who? _____						_____
Is your child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how old was your child? _____						_____
<b>A. Your Child's Development:</b>						_____
Please list the approximate age at which your child:						_____
	Age		Problems			_____
Walked	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
Talked	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
Toilet Trained	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
Puberty/1 <sup>st</sup> Menstruation	_____	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
Sexually Active	_____	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
<b>B. Family History:</b>						_____
Has anyone in your immediate family ever had any of the following problems?						_____
1. Epilepsy or Diabetes?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
2. Significant Medical Problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
3. Mental Illness Requiring Hospitalization?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
4. Counseling For Emotional Problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
5. Current or past use of alcohol/drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
6. Suicidal Behavior?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____









## 15 Symptoms of Social Delays

If you can answer two or more of these symptoms about yourself or your child, this may indicate a need for help to connect socially with your peers and to prepare for the real world.

Please indicate which of these symptoms you have noticed in yourself or your child:

- Unable to recognize non-verbal cues
- Tendency to get in peers' personal space
- Annoy others to get attention
- Low self confidence
- Poor eye contact
- Only interested in myself/or them-self rather than asking an interest in peers
- Talk too much
- Lack assertion
- Impulsive or blurt out responses
- Try too hard to make friends laugh
- Inability to roll with conflict
- Have a need for justice and fairness and judges peers
- Isolate or withdraw from peers
- Always want to be first or want things my/or their way
- Friends do not call to hang out!



### Victimization History

**Abuse:**

Physical:

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Sexual:

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Mental:

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Neglect:

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Domestic Violence:

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Past C.P.S. Involvement:

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Potentially Abusive Behavior:

Substance	Onset	Current	Highest	Most Recent	Tolerance/Withdrawal
Alcohol					
Marijuana					
Cocaine					
Depressants					
Amphetamines					
Hallucinogens					
Opiates					
Inhalants					
K2, Bath salts, spice					
Other					
Tobacco					
Caffeine					



### Authorization of Release Form

Our therapists may find it helpful to consult with your attorney, doctor, school, or applicable parties regarding treatment. In order to consult we need your authorization. If applicable, please complete on for each contact.

I, \_\_\_\_\_, hereby authorize Total Life Counseling Center, 1507 S. Hiwassee Road, Orlando, FL 32835 to:

Release information of: \_\_\_\_\_  
Name of Client Date of Birth

To/From: \_\_\_\_\_  
(family, doctors, psychologist, schools, etc.)

Phone #/Email: \_\_\_\_\_

(Please specify if you only want to authorize for appointments and payments.)

- For the purpose of:
- Outpatient/Inpatient Counseling
  - Coordination with schools
  - Coordination with MD/Psychologist/OT Therapist/Therapist
  - Coordination with other family members

*I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.*

This consent will expire on (optional) \_\_\_\_\_

\_\_\_\_\_  
Client, Parent, Guardian Date

\_\_\_\_\_  
Witness Date



## Informed Consent & Release of Liability

Name: (please print): \_\_\_\_\_

I understand the following:

1. Counseling services are provided by practitioners who have earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who have been licensed by the state of Florida as Mental Health Counselors, Registered Mental Health Counselor Interns (under the supervision of a License Mental Health Counselor Supervisor).
  - a. **Licensed Mental Health Counselors:** Jim West, Jamie Barrett, Matthew Martin, Stephanie Booth, Adriana Carreno, Sherecka Brown, Gemima McMahon
  - b. **Licensed Marriage & Family Therapist:** Lyris Steuber
  - c. **Licensed Clinical Social Worker:** Dana West
  - d. **Registered Mental Health Counselor Intern:** Brandon Feinberg, David Bolanos, Judy Irizarry, Chaliz Demuth, Dawn Helwig, Didem Alpaslan & Jaimie Homan
  - e. **Licensed Professional Counselor:** Anna Vita
  - f. **School Psychologist:** Dr. Marilyn Card
  - g. **Graduate Student Intern:** Valentina Stanley
    - i. A graduate student who is earning a Master's Degree in the field of counseling from an accredited graduate program and who is supervised by Licensed Mental Health Counselors by the State of Florida.
2. Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
3. Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
4. This counselor is not providing an emergency service; therefore, at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance.
5. Regular attendance will produce maximum results, but I am free to discontinue treatment at any time. A final closure/summary session is highly recommended to get the greatest benefits.
6. I understand that my counseling records & conversations with the counselor are kept confidential, except where disclosure is required by law (i.e. abuse of a child, elderly or disable person; potential harm or threat to self or others and specific information subpoenaed by a court of law.)
7. I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.
8. I acknowledge that I may be given the option for telehealth when in-office sessions are not available and understand that it is my responsibility to make sure I maintain my own confidentiality while doing a virtual session.

All group members agree if the therapist is sued for breach of confidentiality, the client who breached confidentiality will hold the therapist harmless from any damages including attorney fees. Consequences of breaching confidentiality may result in pressed charges by another client. Although confidentiality agreements have been signed by all group members, this does not guarantee that confidentiality will not be breached by fellow group members.

My signature below indicated that I grant informed consent for Total Life Counseling to provide counseling services to myself and or minor members of my family.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## 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 about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

<p>The Health Insurance Portability &amp; Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.</p> <p>Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.</p> <ul style="list-style-type: none"> <li>• <i>Treatment</i> means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.</li> <li>• <i>Payment</i> means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.</li> <li>• <i>Health Care Operations</i> include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.</li> </ul> <p>In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by</p>	<p>law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.</p> <p>Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.</p> <p>You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:</p> <ul style="list-style-type: none"> <li>• The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.</li> <li>• The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.</li> <li>• The right to request an amendment to your PROTECTED HEALTH INFORMATION.</li> </ul>	<p>outside of treatment, payment and health care operations.</p> <ul style="list-style-type: none"> <li>• The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.</li> </ul> <p>We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.</p> <p>You have the right to file a formal, written complaint with us at the address below, or with the Department of Health &amp; Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.</p> <p>For more information about our Privacy Practices, please contact:          The Privacy Officer          Total Life Counseling          1507 S. Hiawassee Road #101          Orlando, FL 32835          (407) 248-0030</p> <p>For more information about HIPAA or to file a complaint:          The U.S. Department of Health &amp; Human Services          Office of Civil Rights          200 Independence Avenue, S.W.          Washington, D.C. 20201          877.696.6775 (toll-free)</p>
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**Individual, Family, Marriage & Group Counseling**

P: 407-248-0030

F: 407-248-0226

Satellite Locations:

Winter Park, East Orlando, Clermont & Lake Mary

**Acknowledgement of Receipt: Privacy Practice Notice**

I, \_\_\_\_\_ have received a copy of Total Life Counseling Center Notice of Privacy Practices.

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Client

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Children/Teen Referral

## Holistic Doctors

Dr. Jeff Haskel, PhD.  
Energetic Life  
(407) 647-2220

Dr. Kirt Kalidas, MD- Holistic  
The Center for Natural & Integrative  
Medicine  
(407) 355-9246

Dr. Scott Vanlue, MD – Holistic  
Everything Well  
(407) 862-5637

Paul Sorchy,  
Clermont Chiropractic  
(352) 394-7577

Dr. Lee, Acupuncture & Holistic  
Medicine (Clermont, FL)  
(352) 243-1311

## Family Physician & Dietician

Alilin Family Medicine  
(407) 657-2111

Dr. Jennifer Bourst Unity Family  
Chiropractic Center  
407-460-0985

Dr. Rick Baxley  
(407) 246-7001

Alice Baker, RD, LDN – Dietician  
Joyful Nutrition  
(407) 340-8251

Dr. Jennifer Bourst  
Unity Family Chiropractic Center  
(407) 460-0985

## ORLANDO – Family Law

Tom Marks- Attorney  
The Marks Law Firm – Family Law  
(407) 872-3161

Rebecca Palmer - Attorney  
The Orlando Family Firm  
(407) 377-6399

Compass Law  
(407) 896-1166

Diane N. Holmes – Attorney  
N. Diane Holmes, PA, Family Law  
(407) 843-1744

Anthony Diaz – Attorney – Mediation  
& Collaborative Law  
Center for Professional Legal Services  
(407) 647-7887

Aubrey Harry Ducker, Jr.  
Attorney and Counselor at Law  
407-645-3297

## Resources for Special Needs Children

Aliccia Braccia School Psychologist  
(407) 718-4430

Bright Feats - Orlando Resources  
(407) 620-9355

Achieve Pediatric Therapy, Heather Gray  
(407) 668-4923 (Dr. Phillips) or  
(407) 277-5400 (East Orlando)

## Occupational Therapist

Learn to Learn  
(407) 275-5550

Achieve Pediatric Therapy  
(407) 277-5400

Learning RX  
Betsy Clements  
407-614-6255

## LAKE MARY -Family Law

Elaine Silver  
Collaborative Divorce lawyer  
407-268-6830

## CLERMONT – Family Law

Boyette Cummins & Nailos – Attorney  
BCN Law Firm  
(352) 394-2103

J.J. Dahl - Dahl Family Law Group (352)  
243-4100

Pamela J. Helton – Attorney  
The Law Offices of Pamela Helton, PA  
(352) 243-9991

## Pediatricians

Dr. Barry Yarckin  
West Orange Pediatrics  
(407) 290-9355

Dr. Cardona  
Windermere Pediatrics  
(407) 297-0080

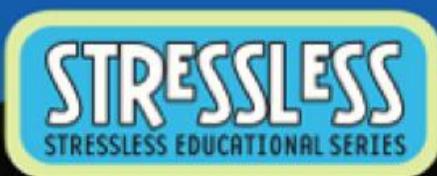
Dr. Cornelia Franz  
(407) 857-8860

Dr. Usmani, Dr. Patel  
Clermont Pediatrics  
(352) 394-7125

Dr. Jill Watson  
(352) 536-9336

Dr. Janette Rivera  
(352) 536-9336

Dr. Cannizzaro 321- 280-5867



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## Psychiatrist

Dr. Heidi Napolitano, MD  
The Happy Mind Company  
(407) 704-1461 – Southwest Orlando

Dr. Morales  
Child Psychiatrist – Oviedo  
(407) 365-0440

Dr. Syed Quadri  
(407) 270-7702

Dr. Herndon Harding  
(407) 671-0057 – Winter Park

Dr. Andrew Pleener  
407-868-1514

Dr. Dhungana  
Serenity Health  
(352) 241-9282

## Residential Addictions

Central Florida Behavioral Hospital  
(407) 370-0111

Next Generation Village  
866-945-4271

La Amistad Behavioral Health (Maitland)  
(407) 647-0660

The Grove  
(407) 327-1765

Seminole Mental Health  
(407) 831-2411

Darryl Strawberry Recovery Center  
(855) 973-7333

## Vitamin Store

Vitamin Shoppe  
Chamberlin's Natural Foods  
(407) 352-2130

Clermont Herb Shoppe & Day Spa  
(352) 243-3588

## Psychologist

William Steven, PhD –  
Educational and Forensic Psychologist  
Central Florida Psychological Consultants  
609 West Montrose, Clermont, Florida  
34711  
(352) 365-2243

Dr. Charlene Messenger –  
Educational Psychologist  
(407) 895-0540

Alicia Braccia, MA, CAS, ABSNPFI –  
School & Educational  
Center for Health Learning & Achievement  
(407) 718-4430

Clarice L. Honeywell, M.S., NCSP –  
School/Educational  
The Psychology & Counseling Group  
(407) 523- 1213

Dr. Patrick Gorman, DPSY,  
PSYD – Neuro – Developmental  
(407) 644-7792

Denton Kurtz, School Psychologist  
(407) 629-9003

Dr. Joanne Cook, EdD – Psychologist  
1316 Palmetto Avenue, Winter Park, FL  
32789  
(407) 740-5259

Stacy Carmichael – Psychological Eval  
727-481-2444

## Eating Disorder IOP

Blue Horizons, partnered with Remuda  
Ranch  
(407) 719-6294

Eudine Harry MD  
Center for Medical Weight Loss of  
Orlando  
(407) 480-3339

Wekiva Springs Center (Jacksonville)  
(904) 296-3533

Rega Mental Health Center (Coral  
Springs)  
(954) 346-8300

Renew Center of Florida (Boca Raton)  
(954) 907-3446

## Center for Speech & Language

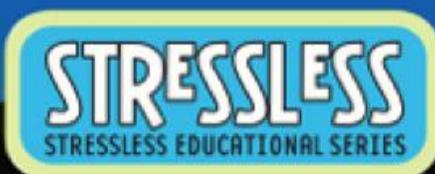
Rhonda Hemphill, M.S. CCC-SLP  
407-299-1533

## Visual Therapy

Dr. Toler  
Hope Vision Development  
352-243-4673

## Autism Referrals

Paula Breeden -  
407-463-3857



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