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 important to have

Directions:
For directions to our location, please download the maps at totallifecouseling.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

Should you need further assistance or an emergency arises before we can meet, please feel

STRESSLESS
STRESSLESS EDUCATIONAL SERIES
StressLessSeries.com

TOTAL LIFE COUNSELING
TotalLifeCounseling.com

407.248.0030 Info@TotalLifeCounseling.com Total Life Main Office, 1507 S. Hiawassee Road, Suite #101, Orlando, FL 32835

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F: 407-248-0226
Satellite Locations:
East Orlando, Clermont, Winter Park & Lake Mary

GENERAL INFORMATION

Date: _____ How did you hear about us? _____ May we send a thank you gift? _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. _____

Name You Prefer: _____

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____ Parent/Guardian: _____

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Mobile Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes ☐ No

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

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

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary:
☐ $0 to $10,000 ☐ $10,001 to $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $50,000 ☐ $50,001 to $60,000 ☐ $60,001 to $80,000 ☐ $80,001 to $100,000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

Are You Currently in School: ☐ Yes ☐ No. If Yes, What School: _____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

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If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Biological, Adopted, Step)*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ☐ Yes ☐ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling,Step)*	Occupation	Describe Him/Her

Do You Have a Personal Support System: ☐ Yes ☐ No. If Yes, Who: _____

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: _____

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Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary)*: _____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches	☐ Past	☐ Present	Dizziness	☐ Past	☐ Present	Stomach Trouble	☐ Past	☐ Present
Visual Trouble	☐ Past	☐ Present	Sleep Trouble	☐ Past	☐ Present	Trouble Relaxing	☐ Past	☐ Present
Weakness	☐ Past	☐ Present	Tension	☐ Past	☐ Present	Rapid Heart Rate	☐ Past	☐ Present
Difficulty Breathing	☐ Past	☐ Present	Intestinal Trouble	☐ Past	☐ Present	Hearing Noises	☐ Past	☐ Present
Change in Appetite	☐ Past	☐ Present	Tiredness	☐ Past	☐ Present	Pain	☐ Past	☐ Present
Hearing Voices	☐ Past	☐ Present	Seeing Things	☐ Past	☐ Present	Other	☐ Past	☐ Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress	☐ Past	☐ Present	Nervousness	☐ Past	☐ Present	Anxiety	☐ Past	☐ Present
Panic	☐ Past	☐ Present	Unhappiness	☐ Past	☐ Present	Depression	☐ Past	☐ Present
Guilt	☐ Past	☐ Present	Apathy	☐ Past	☐ Present	Terminal Illness	☐ Past	☐ Present
Recent Death	☐ Past	☐ Present	Grief	☐ Past	☐ Present	Hopelessness	☐ Past	☐ Present
Inferiority Feelings	☐ Past	☐ Present	Defective Feelings	☐ Past	☐ Present	Loneliness	☐ Past	☐ Present
Shyness	☐ Past	☐ Present	Fears	☐ Past	☐ Present	Friends	☐ Past	☐ Present
Marriage	☐ Past	☐ Present	Communication	☐ Past	☐ Present	Physical Abuse	☐ Past	☐ Present
Emotional Abuse	☐ Past	☐ Present	Verbal Abuse	☐ Past	☐ Present	Sexual Abuse	☐ Past	☐ Present
Temper	☐ Past	☐ Present	Anger	☐ Past	☐ Present	Aggressiveness	☐ Past	☐ Present
Bad Dreams	☐ Past	☐ Present	Concentration	☐ Past	☐ Present	Racing Thoughts	☐ Past	☐ Present
Unwanted Thoughts	☐ Past	☐ Present	Memory	☐ Past	☐ Present	Loss of Control	☐ Past	☐ Present
Impulsive Behavior	☐ Past	☐ Present	Self-Control	☐ Past	☐ Present	Compulsivity	☐ Past	☐ Present
Sexual Problems	☐ Past	☐ Present	Pregnancy	☐ Past	☐ Present	Abortion	☐ Past	☐ Present
Legal Matters	☐ Past	☐ Present	Trauma	☐ Past	☐ Present	Eating Problems	☐ Past	☐ Present
Drug Use	☐ Past	☐ Present	Alcohol Use	☐ Past	☐ Present	Trouble with Job	☐ Past	☐ Present
Career Choices	☐ Past	☐ Present	Ambition	☐ Past	☐ Present	Making Decisions	☐ Past	☐ Present
Children	☐ Past	☐ Present	Being a Parent	☐ Past	☐ Present	Finances	☐ Past	☐ Present
Recent Loss	☐ Past	☐ Present	Disaster	☐ Past	☐ Present	Smoke Cigarettes	☐ Past	☐ Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐ Yes ☐ No. Have You Experienced Them in the Past: ☐ Yes ☐ No

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Have You Ever Attempted Suicide: ☐ Yes ☐ No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ☐ Yes ☐ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?):* _____

Why Have You Decided to Come for Counseling Now: _____

What Do You Hope to Gain or Change by Coming for Counseling: _____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary):*

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

_____

ACTIVITIES, INTERESTS, & STRENGTHS

What do you do in your spare time? _____

What do you do well? _____

TERMS OF SERVICE

I hereby give Total Life Counseling Center permission to provide counseling services for the client mentioned above:

Signed: _____ Date: _____

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Victimization History

Abuse:

Physical:

Sexual:

Mental:

Neglect:

Domestic Violence:

Past C.P.S. Involvement:

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					

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Authorization of Release Form

Our therapists may find it helpful to consult with your spouse, partner, 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. Hiawassee 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

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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: _____

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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.

The Health Insurance Portability & 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.

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.

・*Treatment* 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.

・*Payment* 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.

・*Health Care Operations* 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.

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 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.

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.

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:

・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.

・The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

・The right to request an amendment to your PROTECTED HEALTH INFORMATION.

・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 PROTECED HEALTH INFORMATION.

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.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & 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.

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

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775 (toll-free)

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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:_____

Witnessed Signed: _____ Date:_____

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Relationship Questionnaire

1. List the things that your partner does that please you:

2. What would you like your partner to do more often?

3. What would your partner like for you to do more often?

4. How do you contribute to difficulties in the relationship?

5. What are you prepared to do differently in the relationship?

6. Is there a problem of alcohol/substance abuse?

7. Have you or your partner participated in any of the following activities:
   - ☐ Swinging
   - ☐ Pornography
   - ☐ Fetishes

8. Do you often try to anticipate your partner's wishes so that you can please them?

9. What are your goals or what do you hope to accomplish?

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This questionnaire is intended to estimate the current satisfaction with your relationship. Circle the number between 1 (completely satisfied) to 10 (completely unsatisfied) beside each issue. Try to focus on the present and not the past.

	Completely satisfied									Completely unsatisfied
General Relationship	1	2	3	4	5	6	7	8	9	10
Personal Independence	1	2	3	4	5	6	7	8	9	10
Spouse Independence	1	2	3	4	5	6	7	8	9	10
Couples Time Alone	1	2	3	4	5	6	7	8	9	10
Social Activities	1	2	3	4	5	6	7	8	9	10
Occupational or Academic Progress	1	2	3	4	5	6	7	8	9	10
Sexual Interactions	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Financial Issues	1	2	3	4	5	6	7	8	9	10
Household/Yard Responsibility	1	2	3	4	5	6	7	8	9	10
Parenting	1	2	3	4	5	6	7	8	9	10
Daily Social Interaction	1	2	3	4	5	6	7	8	9	10
Trust in Each Other	1	2	3	4	5	6	7	8	9	10
Decision Making	1	2	3	4	5	6	7	8	9	10
Resolving Conflicts	1	2	3	4	5	6	7	8	9	10
Problem Solving	1	2	3	4	5	6	7	8	9	10
Support of One Another	1	2	3	4	5	6	7	8	9	10

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Please do not write in space below. For office use only

Issues	Descriptions & Objectives	Interventions

Diagnostic Impressions:

Axis I: _____

_____

Referrals

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. Steve Antonio – Whole Family Health

Dr. Jennifer Bourst
Unity Family Chiropractic Center

Family Physician & Dietician

Allilin Family Medicine
(407) 657-2111

Dr. Rick Baxley
(407) 246-7001

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

Occupational Therapist

Learn to Learn
(407) 275-5550

Achieve Pediatric Therapy
(407) 277-5400

Center For Speech & Language
Rhonda Hemphill, M.S. CCC-SLP
407-299-1533

Orlando

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

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

Rebecca Palmer – Attorney
The Orlando Family Law Firm
(407) 377-6699

Anthony Diaz – Attorney – Mediation & Collaborative Law
Law Office of Anthony J. Diaz
(407) 774-4949

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

Compass Law
407-869-1166

Teresa Parnell Psy.D
Drparnell.net
407-862-2722

Lake Mary

Elaine Silver
Collaborative Divorce lawyer
407-268-6830

Personal Injury Attorneys

Wade Boyette
Boyett Offices
(352) 394-2103
Fax: (352) 394-2105

Umansky Law Firm
(407) 228-3838
Fax: (407) 228-9545

Clermont

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

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

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

OBGYN

Mark Bielawny
David Hazel-Ann Family Practice
407-381-7364

Dr. Joseph Kerpsack
352-241-7050

Dr.Andrew Karen
Southlake Hospital
352-241-7275

Vitamin Store

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

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

Resources for Special Needs Children

Aliccia Braccia School Psychologist
Orlando Resources
(407) 718-4430

Achieve Pediatric Therapy, Heather Gray

(407) 668-4923 (Dr. Phillips) or
(407) 277-5400 (East Orlando)

Bright Feats -

(407) 620-9355

Psychiatrist

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

Dr. Dhungana
Serenity Health
(352) 241-9282

Dr. Syed Quadri
(407) 270-7702

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

Dr. Alvarez-Jacobs
Esperanza Behavioral Health
(407) 226-3733

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

Eating Disorder IOP

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

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

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

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

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

Visual Therapy

Dr. Toler
Hope Vision Development
352-243-4673

Psychologist

Dr. Marilyn Card, PhD
Total Life Counseling/Card Counseling Testing Evaluations & Services
(407) 248-0030

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

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The Psychology & Counseling Group
(407) 523-1213

Dr. Patrick Gorman, DPSY, PSYD – Neuro- Developmental
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Alex Sanchez, LLC- Neuro Feedback /Neuro therapy & Biofeedback Therapist
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Criminal Attorneys

Joe Pate – Attorney
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(407) 896-1166

Zahra Umansky
Umasky Law Firm – Criminal & Juvenile
(407) 228-3838

Bill Umansky
(407) 599-3838

Anthony Diaz
(407) 774-4949

Autism Referrals

Paula Breeden -
407-463-3857

Residential Addictions

Central Florida Behavioral Hospital
(407) 370-0111

Center for Drug Free Living
(407) 245-0014

La Amistad Behavioral Health (Maitland) – Adults & Adolescents
(407) 647-0660

Family First Adolescents – Palm Beach Gardens
(561) 328-7370

Impower- The Grove
(407) 215-0095

Seminole Mental Health
(407) 831-2411

The Blackberry Center
(855) 973-7333

The Recovery Village
(352) 800-6077

Inpatient for adults

Central Florida Behavioral
(407) 370-0111

La Amistad
(407) 647-0660

University Behavioral Center – Baker Act
(407) 281-7000

Seminole Community Mental Health
(407) 831-2411

Lakeside
(407) 291-6335

American Addictions Center
Ryan Aldrin
407-450-0947

Advanced Recovery
Kevin Reese
844-291-6185

Lifestream Behavioral
(866) 355-9394