I do hereby request to receive therapeutic services from Sharon Dunbar, MSW, LCSW for myself:

Name:______________________________________**DOB:**________________

Address: ____

Primary Phone:__________________**Other Phone:**___________________**Email:**___________________

Services may include one or more of the following: Individual, Couple, Family, or Group Psychotherapy. I understand that while all reasonable effort will be made to accomplish the goals of the treatment plan as designed, Sharon T. Dunbar, MSW, LCSW does not guarantee the result of the treatment plan. It is further understood that all information given by the client or any family member to Sharon T. Dunbar, MSW, LCSW is confidential and will not be released without written permission. ***Exceptions: Suicidal or homicidal thoughts and or intent to harm self or others or knowledge of sexual or physical abuse of a child or elder.***

____
Client Signature **Date**

____
Witness Signature **Date**

Personal Information:

☐ **Married** ☐ **Living together** ☐ **Single** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

☐ **Unemployed** ☐ **Student** ☐ **Retired** ☐ **Employed full time** ☐ **Employed part time**

Employer:______________________ **Occupation:**___________________________________

Members of household or adult children:

Name	Age	Relationship	Name	Age	Relationship

Medications: ____

List all surgeries:____

Medical illnesses (past, current or chronic):____

Prior Mental Health Treatment: ____

Name of Psychiatrist: ____

Consent and Disclosure of Protected Health Information

Use and Disclosure of Protected Health Information:
Under Florida State Law no Licensed Mental Health Professional may speak to anyone without your written consent. Exceptions to this are made in the case of reporting abuse or neglect, harm to self or others, or involuntary placement (Baker Act).

Notice of Privacy Practices:
You should review the notice of Privacy Practices for a more detailed and complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this document.

Requesting a Restriction on the use or Disclosure of your Information:
For purposes of continuity of care and only to benefit treatment Clearview Counseling and Coaching LLC may communicate with your other healthcare providers. This **will only be done with a separate consent** outlining the terms of what may be disclosed. You may request a restriction on the use of disclosure of your protected health information. Clearview Counseling and Coaching LLC may or may not agree to restrict the use or disclosure of your health information. If Clearview Counseling and Coaching LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreement upon restriction will be a violation of Federal Privacy Standards.

Revocation of Consent:
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent was received will not be affected.

Reservation of Right to Change Privacy Practices:
Clearview Counseling and Coaching LLC reserves the right to modify the privacy practices outlined in the notice.

I_____________________________have reviewed the Notice of Privacy Practices Information. I consent and give permission to Clearview Counseling and Coaching LLC to use and disclose my health information in accordance with it.

____

Signature Date

Emergency Contact Information

This information will only be used in the case of an emergency such as an accident, medical emergency, or hospitalization. Signing this form gives Clearview Counseling and Coaching LLC the authority to contact the individuals on this form should the need arise as described in the above circumstances.

Your Name: ______________________________

Phone:______________________ Alternative Phone: ______________________

Address: ______________________________

Primary Emergency Contact Name: ______________________________

Relationship to you: ______________________________

Phone:______________________Alternative Phone:______________________

Secondary Emergency Contact Name: ______________________________

Relationship to you: ______________________________

Phone:______________________Alternative Phone: ______________________

Name of Primary Doctor: ______________________________

Address:______________________________

Phone: ______________________________

Any special medical or personal information that emergency personnel should know to assist you in crisis (list all medical conditions) :

____

____

____

____

Signature:______________________________Date:________________

Office Policy & Financial Agreement

Name of Client: ____

Address: ____

Name of Guarantor if other than Client: ____

Telephone #:______________________________**Alternate #:** ____________________________________

Insured Clients:

Clearview Counseling and Coaching LLC will not disclose any information to insurance companies. We will provide you with a receipt outlining date of service, diagnosis if applicable, provider's name, address, and phone number, and the charge. If you should decide to seek reimbursement from your insurance company, you may submit the receipt on your behalf.

Payment Policy:

Payment is due at the time of service. I agree to pay $200.00 up to one-hour session. Sessions that excessed one hour with be charged an additional $50.00 per 15-minute increments.

Cancellation Policy:

If you are unable to keep your appointment, the office will request forty-eight (48) hours advance notice. This will permit enough time to provide service to another client. ***Appointments missed without 48 hours notice will be billed to the credit card on file at the rate of $200.00.***

I have read the above policies and understand and agree to the conditions as established and listed above.

Signature:________________________________**Print Name:** ____________________________________

Witness:__________________________________**Print Name:** **Sharon T. Dunbar, LCSW**_____________

Date: _____________

Facilitating Clarity from Within

Please answer all the following questions to the best of your ability. These answers will assist with your treatment and diagnosis.

Name:_______________________________Date of Birth:______________Date: _____________

When thinking about the past two weeks have you experienced the following? Mark all that apply:

- ☐ Depressed mood most of the day; nearly every day.
- ☐ Markedly diminished interest or pleasure in most activities
- ☐ Significant increase or decrease in food intake
- ☐ Sleeping less or having trouble falling asleep
- ☐ Sleeping more than 8 hours in a 24-hour period – if yes how many hours ______
- ☐ Has anyone noticed you are sluggish or jittery
- ☐ Loss of energy
- ☐ Feeling worthless or excessive guilt
- ☐ Difficulty concentrating
- ☐ Difficulty making decisions
- ☐ Recurrent thoughts of death
- ☐ Recurrent thoughts of suicide

When thinking about the past 6 months mark all that apply:

- ☐ Excessive worry about several activities or events
- ☐ Difficulty sleeping or falling asleep
- ☐ Restlessness or feeling keyed up
- ☐ Being easily fatigued
- ☐ Difficulty concentrating or mind going blank
- ☐ Irritability
- ☐ Muscle tension

Name:________________________

Mark all that apply:

- ☐ Palpitations, pounding heart, or accelerated heart rate
- ☐ Sweating
- ☐ Trembling or shaking
- ☐ Sensations of shortness of breath
- ☐ Feelings of choking
- ☐ Chest pain or discomfort
- ☐ Nausea or abdominal distress
- ☐ Feeling dizzy, unsteady, light-headed, or faint
- ☐ Chills or heat sensations
- ☐ Numbness or tingling sensations
- ☐ Feelings of unreality or being detached from oneself
- ☐ Fear of losing control
- ☐ Fear of dying

Have you seen a doctor regarding any of the above symptoms? ☐ Yes ☐ No

Have you ever experienced any of the following? Mark all that apply:

- ☐ Inflated self-esteem or grandiosity
- ☐ Decreased need for sleep
- ☐ More talkative than usual or pressure to keep talking
- ☐ Racing thoughts
- ☐ Distractibility
- ☐ Risk taking; ie: spending sprees, risky sexual encounters, impulsive business

Name:________________________

Describe your alcohol/substance use over the past year:

How often do you have a drink containing alcohol? ☐ rarely ☐ weekly ☐ daily

How many drinks do you have when drinking? ☐ 1-2 ☐ 3-4 ☐ 5 or more

Have you ever felt that you could not stop drinking once you started? ☐ yes ☐ no

Have you ever not done what you planned because of drinking or other substance use?

☐ yes ☐ no

Have you ever needed a drink or substance to get going in the morning? ☐ yes ☐ no

Have you felt guilt or remorse for using alcohol or another substance? ☐ yes ☐ no

Have you ever not been able to remember what you have done after using alcohol or another substance? ☐ yes ☐ no

Have you or another been injured while you were intoxicated? ☐ yes ☐ no

Has anyone suggested that you cut back or quit drinking or using substances? ☐ yes ☐ no

Did anyone in your family drink or use substances? ☐ yes ☐ no

If so who? ____

In the past have you been physically hurt or been forced to perform an unwanted sexual act?

☐ yes ☐ no

Have you ever been touched in a way that made you feel uncomfortable? ☐ yes ☐ no

Have you ever been the target of emotional abuse? ☐ yes ☐ no

Clearview Counseling and Coaching LLC collects a means of payment from each client at the beginning of our relationship. We are happy to allow you to pay for sessions via cash or check, however, we still request a card to keep on file.

I authorize Clearview Counseling and Coaching LLC to keep my signature on file and to charge fees, or partial fees, to my credit, charge or debit card account for services provided to:

____

Client Name

I understand that this authorization is valid until canceled in writing. I understand that charges for ongoing services will normally be posted to my credit card account within 3 days of each service date. I understand that appointments not canceled in line with our cancellation policy will incur the normal charge.

I agree that if I have any problems or questions regarding charges to my account, I will contact Clearview Counseling and Coaching LLC for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Clearview Counseling and Coaching LLC and those attempts have failed.

____

Cardholder Name

____

Address including zip code

__________________________ ___________ ___________

Credit Card Number Expiration Date CVC Number

____

Signature Date