DR. ANDREW GRAHAM
PROFESSIONAL COUNSELING FROM A CHRISTIAN PERSPECTIVE

Counseling Policies and Procedures

COUNSELING SESSIONS:

Counseling sessions last at least fifty (50) minutes, a clinical hour, unless previously arranged. Sessions are typically scheduled Monday through Thursday at 11:00 am, 1:00 pm, 2:30 pm, and 4:00 pm.

CANCELLATIONS AND RESCHEDULING:

If you must cancel your appointment, notify me by text or email as soon as possible. Repeated cancellations will mean that further appointments may not be scheduled.

FEES FOR COUNSELING:

The fee for your counseling sessions is $70 per clinical hour. Counseling fees are due at the end of each session. You may pay by cash or check, CashApp or PayPal.

INSURANCE AND RECEIPTS:

I do not accept insurance but I can provide you with a receipt for your services along with the proper coding information (when appropriate) for you to submit to your insurance provider.

EMERGENCY SITUATIONS:

If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. I am not able to provide on-call emergency services.

CREDENTIALING:

I am credentialed with the following organizations and designations (with license numbers):

State of Florida	Licensed Mental Health Counselor	12564
National Board for Certified Counselors	National Certified Counselor	328575
International Board of Christian Care	Board-Certified Professional Christian Counselor	1178

CONTACTING US:

You may email me via text or email at the numbers provided.

Voicemail: (772) 245-7430
Email: christiancounselingadvice@gmail.com

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Informed Consent and Release of Liability

Name: _____

I understand that my counselor is working under Florida laws, rules and statutes as a Licensed Mental Health Counselor.

I understand that my counseling records are kept confidential, except where disclosure is required by law or the ethics of the counseling profession (i.e. abuse of a child, elderly or disabled person; potential harm or threat to self or others; child custody cases that go before a court of law; and specific information subpoenaed by a court of law).

In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Dr. Andrew Graham from any and all claims, demands, actions, or causes of action of whatsoever kind and nature related to the counseling process.

The clinical records are the property of Dr. Andrew Graham and are deemed records of confidential sessions between therapists and clients. I waive any right I may otherwise have to seek to use the clinical records as evidence in any judicial proceedings.

Counseling sessions last fifty (50) minutes, a clinical hour, unless previously arranged. I understand that, if I must cancel my appointment, I am to provide notification by text or email as soon as possible. I understand that repeated cancellations will mean that further appointments may not be scheduled.

I understand that the fee for each counseling sessions is $70 per clinical hour and that counseling fees are due at the end of each session. I understand that I may pay by cash or check, CashApp or PayPal. I understand that Dr. Andrew Graham does not accept insurance.

I understand that, if at any time I become extremely emotionally distressed or are in danger of hurting myself or someone else, I have been instructed to call 911 for assistance because Dr. Andrew Graham is not able to provide on-call emergency services.

My signature below indicates that I grant informed consent for Dr. Andrew Graham to provide psychological services and counseling to myself and/or minor members of my family. I acknowledge having received the Notice of Privacy Practices*.*

_____ _____

Client Signature Date Client Signature Date

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Confidential Client Information Form

GENERAL INFORMATION

Name: _____

Date: _____ Referred by: _____

Age: _____ Sex: ☐ Male ☐ Female

CONTACT INFORMATION

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Preferred? ☐ Yes ☐ No

Email: _____ Preferred? ☐ Yes ☐ No

Google Hangout/Zoom ID (for online): _____

EMERGENCY CONTACT

Name: _____

Phone: _____ Relationship: _____

RELATIONAL INFORMATION

Describe your relationship to your primary caregivers when you were a child:

_____

_____

Describe your current home and relationships to those you live with:

_____

_____

_____

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RELIGIOUS BACKGROUND

Church: _____

Describe your current relationship with God:

_____

_____

_____

PRESENTING ISSUES AND GOALS

Describe why you're seeking counseling at this time:

_____

_____

_____

Describe what you hope to gain or change by coming for counseling:

_____

_____

_____

LEVEL OF DISTRESS

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No

Have any of your friends or family ever attempted suicide? ☐ Yes ☐ No

PREVIOUS COUNSELING

Describe any previous counseling, psychiatric treatment, or residential/in-patient counseling:

_____

_____

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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.

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 me in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you significant 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, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information.

Without specific written authorization, I am permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

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.

I will use and disclose your PROTECTED HEALTH INFORMATION when I am required to do so by federal, state or local law. I 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 I have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. I may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. I 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, I 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 I am required to honor and abide by that written request, except to the extent that I 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:
-The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I 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 me by alternative means or at alternative locations.
-The right to request an amendment to your PROTECTED HEALTH INFORMATION.
-The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
-The right to obtain a paper copy of this notice upon request.

I am required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of me legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of my Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that I maintain. Revisions to my Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice. You have the right to file a formal, written complaint with me or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. I will not retaliate against you for filing a complaint.
For more information about our Privacy Practices, please contact me.

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