

# Natural Medicine Center of Lakeland

Eileen Templin, LCSW, RYT

315 Doris Drive, Lakeland, FL 33813

---

## General Information Form

Welcome to our office. Your cooperation in completing this form will enable me to provide you with the most appropriate assistance.

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work or Cell Phone (\_\_\_\_) \_\_\_\_\_

Your place of employment \_\_\_\_\_

Your position or title \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_

Children Name/Age \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Spouse Name/Age \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

## Health/Lifestyle Inventory

Current or recent health concerns/physical problems \_\_\_\_\_

---

---

---

Allergies \_\_\_\_\_

Current stressors in your life \_\_\_\_\_

---

---

---

Current medications \_\_\_\_\_

---

---

Over the counter drugs \_\_\_\_\_

---

Herbal/Nutritional supplements \_\_\_\_\_

---

---

Birth Control Pills or Hormone Replacement Therapy \_\_\_\_\_

---

Are you satisfied with the state of your health? \_\_\_\_\_

Why or Why not? \_\_\_\_\_

---

---

How would you rate your wellness: (circle)

Chronically ill   Sick a lot   Rarely sick   Neutral   Feel well   Feel vibrant

Which best describes your feelings about your body? (circle)

Hate it   Dislike it   Neutral   Like it   Love it

Are you satisfied with your weight? \_\_\_\_\_

Why or Why not? \_\_\_\_\_

---

---

Do you feel physically fit? \_\_\_\_\_  
Why or Why not? \_\_\_\_\_  
\_\_\_\_\_

Are you satisfied with your energy level? \_\_\_\_\_  
Why or Why not? \_\_\_\_\_  
\_\_\_\_\_

Describe your eating habits and quality of nutrition \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the amount and type of exercise you get \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate YES or NO to the following and the amount:

Cigarettes Y N \_\_\_\_\_  
Caffeine Y N \_\_\_\_\_  
Sugar Y N \_\_\_\_\_  
Alcohol Y N \_\_\_\_\_

Any current compulsive behaviors related to: (circle)

Alcohol	Working	Exercise
Drugs	Spending/shopping	Sex
Smoking	Gambling	Computer
Food/eating	TV	Other

Do you experience PMS or Hormonal imbalance symptoms? Yes No  
If so, describe them: \_\_\_\_\_  
\_\_\_\_\_

Do you experience depression? Yes No

How often do you experience an overall sense of well-being and genuine happiness?  
(Circle)

Never Rarely Occasionally Commonly Frequently

Name \_\_\_\_\_ Date \_\_\_\_\_

## **Memo of Understanding**

### **I. Fees, Insurance, and Cancellation of appointments**

The fee for each session of psychotherapy (55 minutes) is \$95.00. Sessions extending beyond 55 minutes or any telephone consultations over 10 minutes will be charged on a pro-rated basis for the additional time. I am not on insurance network panels, but if you have insurance that pays for out of network out-patient psychotherapy, you can receive a billing statement that you can submit to your insurance company for reimbursement. Payment will still be required at the time of service.

It is important for you to recognize that when you make an appointment, I am reserving that time for you. If you are late, that cuts down on your therapy time. If you miss an appointment, that is time that could have been scheduled for another client. Therefore, I charge for missed appointments where I have not been given 24 hour cancellation notice. The charge for late cancellation or not showing for the appointment is \$50.00. If you do need to cancel, I appreciate as much notice as possible, so that someone else who may be waiting for a cancellation can arrange to come in.

### **II. Spirituality and Religion**

I respect your religious and spiritual beliefs and differences. I feel very comfortable if you choose to include these in your therapy session. I also respect your right not to include this aspect of your life in your session. Please feel free to discuss this subject with me.

### **III. Open Discussion**

Please feel free to discuss openly with me any aspect of your therapy or to ask any questions. I look forward to being a part of your treatment process and feel privileged that you have chosen to do this work with me.

### **IV. Confidentiality**

Confidentiality and privileged communications are rights of all clients of psychotherapists according to the law and professional ethics. No information about you, or the counseling services provided to you, will be released without your consent. There are, however, certain circumstances in which it may be required to release client information. Examples of legal disclosure without consent are: suspected child abuse or neglect, danger to oneself or others and a court order to disclose information. Carefully read and sign the attached HIPPA guidelines.

Your signature indicates that you have read and understood this Memo of Understanding and that you consent to treatment with Eileen Templin, LCSW, RYT.

\_\_\_\_\_ (signature and date)

**Natural Medicine Center of Lakeland**  
**Eileen Templin, LCSW, RYT**  
315 Doris Drive  
Lakeland, FL 33813

**Notice of Social Worker's Policies and Practices to Protect the Privacy of your Health Information**

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

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

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. 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 psychologist.
  - 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 healthcare 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, and 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 my office such as releasing, transferring, or providing access to information about you to other parties.
- “*Authorization*” is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

**II. Other Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment or 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 made about our conversation during a private, group, joint or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (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, law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures without Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances (if at all possible, I will discuss this disclosure with you before it happens):

- *Child Abuse* - If I have reasonable cause to believe a child known to me in my professional capacity may be an abused child or a neglected child, I must report this belief to the proper authorities.
- *Adult and Domestic Abuse* – If I have reason to believe that an individual (who is protected by state law) has been abused, neglected or financially exploited, I must report this belief to the appropriate authorities.
- *Health Oversight Activities* – I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization 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 must be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.
- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

#### **IV. Patient's Rights and Social Worker's Duties**

##### Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, I will discuss with you the details of the request for access process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### Social Worker's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you in writing.

#### **V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me in writing, giving as much information as possible so we can address your concerns.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. My office will provide you with the appropriate address upon request.

#### **VI. Effective Date, Restrictions and Changes to Privacy Policy**

This is effective immediately.

**Your signature indicates that you have read and understood this Memo of Understanding.**

---

Signature

---

Date