Dr. Lewis James Jordan, PhD, LMHC, NCC

Dear New Client(s),

Please pardon the paperwork for our first meeting. I request that you please read, complete, and sign the attached forms and bring them to our first meeting. **Filling them out before our meeting will insure that the time we spend will get to the heart of your needs more directly**.

The following sections needing your attention are as follows:

- Law requires the 'Office Policies & Informed Consent' be reviewed and signed prior to and before we begin our professional relationship.

- The Consent Agreement for Treatment of a Minor is required when treating a child who is 17 years of age or younger. If there has been a divorce and joint custody was awarded, I need the signatures of both custodial parents on the form and a copy of the custody decree.

- The Client Information form provides me with basic information about you and will assist me in attending to your needs. I need each person who will be participating in treatment to fill out this form. Couples have additional forms that are provided.

- ***If you wish to get insurance reimbursement for my services, I will need the 'Authorization to Disclose Protected Health Information,' signed. Please fill out your name and the insurance company name at the top and sign.

- The Treatment, Payment, and Health Care Operations (TPO) Consent form is standard for any health care provider and is required by HIPPA law. It also has a place for you to acknowledge receiving the HIPPA Leaflet. The HIPPA Leaflet is yours to have as a future reference of your privacy rights.

All information is strictly confidential and is filed in a locked file cabinet.

Thank you and welcome,

Dr. Lewis James Jordan PhD, LMHC

Dr. Lewis James Jordan, PhD, LMHC, NCC

OFFICE POLICIES & INFORMED CONSENT AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you with information that is in addition to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the 'Notice of Privacy Practices' leaflet that you received with this form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to others (See also Notice of Privacy Practices).

When Disclosure May Be Required: Disclosure may be allowed when a client presents a danger to self, to property, or is gravely disabled. Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from me. In couple/family therapy, or when different family members are seen individually, confidentiality may not apply. I will use my clinical judgment to support the disclosure of such information. I will not release records to any outside party unless I am authorized to do so by all adult family members who were part of the treatment.

Emergencies: If there is an emergency where I become concerned about your personal safety, I will do whatever I can within the limits of the law, to prevent you from injuring yourself and to ensure that you receive the proper medical care. For this purpose, I may contact the emergency person whose name you have provided on the Client Information Sheet, or other such documentation, as well as 911 and/or local police.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier(PPO/HMO/EAP)in order to process the claims. Only the minimum necessary information will be communicated to the carrier. You must be aware that submitting an invoice for reimbursement can entail some risk to confidentiality, privacy, or future eligibility to obtain health or life insurance. Mental health information is entered into insurance companies' computers and soon will be reported to the congress-approved National Medical Data Bank. Computers are vulnerable to break-ins and unauthorized access; therefore, you could be in a vulnerable position.

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be accessed by unauthorized persons hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to unauthorized access. Faxes can easily be sent erroneously to the wrong address. Please notify me at the beginning of treatment if you decide to avoid or limit the use of the above-mentioned communication devices. **Please DO NOT use e-mail or faxes for emergencies**.

Consultation: I consult regularly with other professionals regarding my clients; however, names or other identifying information are never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

INITIALS_____

* Considering all of the above exclusions, if it is still appropriate, upon your request I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way.

TELEPHONE POLICY & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message on my voice mail and your call will be returned as soon as possible. At times, phone support between sessions may be honored, however, those calls will be billed accordingly. **If an emergency arises, right away, dial 911 from your phone or call your local police department.**

PAYMENTS: therapist and client agree upon Fees by the first session. Clients are expected to pay at the end of the first session and at the beginning of subsequent sessions unless agreed otherwise. Individual sessions are 45-50 minutes long; double-sessions are 90 minutes in length. Telephone conversations, report writing, consultation with other professionals, extended sessions, travel time, etc. will be charged at the same rate unless other arrangements are made. All bounced checks will incur an extra charge of $25.00. Please notify me if any problem arises regarding your ability to make you payments.

INSURANCE REIMBURSEMENT: Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I will provide you with a receipt on a monthly basis, which you can then submit to your insurance company for reimbursement. ***Not all issues that are the focus of psychotherapy are reimbursed by insurance companies.** It is your responsibility to verify the specifics of your coverage. As indicated above in Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries some risk.

THE PROCESS OF THERAPY / EVALUATION: Participating in therapy can result in numerous benefits, including improving interpersonal relationships and resolving the concerns that led you to seek therapy. Working toward these benefits, however, requires active involvement, honesty, and openness on your part. Moreover, while therapy is effective for many people and often leads to significant and lasting changes, there are some risks involved. Many people report discomfort during therapy, since strong and sometimes undesirable feelings can emerge as one considers unpleasant or embarrassing subjects. I may challenge some of your assumptions, or, propose different ways of handling situations that may trigger upsets for you. Attempting to resolve tensions between yourself and others (such as a partner, child or family member) may lead to changes that were not originally intended. Moreover, a decision that is positive for one person, can be viewed quite negatively by another. Change can be easy and swift; but more often it can be slow, and even frustrating. For some people, problems may get worse before they get better. It is also possible that therapy does not work. Even so, many people find that therapy is worth the difficulty it may entail.

Discussion of Treatment: Within a reasonable time after initiating treatment, I will discuss with you (the client) my understanding of the therapeutic issues and objectives, and my view of the possible modalities and outcomes of treatment. During the course of therapy, I am likely to draw on various psychological approaches that include, but may not be limited to behavioral, cognitive-behavioral, transpersonal, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational. If you have any questions about any of the procedures used in the course of your therapy, please ask and you will be answered fully. You also have the right to ask about other treatments and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining that treatment. **INITIALS**_____

Termination: After the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you may contact. Also, if I assess that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you, and, if appropriate; terminate treatment. Likewise, I would give you a number of referrals that may be of help to you. If at any time you want another professional's opinion, I will assist you in finding someone qualified; and, with your written consent, I will provide him/her with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will provide you with names of other qualified professionals whose services you might prefer.

Dual Relationships: Not all dual relationships are unethical or avoidable. However, therapy never involves sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Out in the community I will never acknowledge working therapeutically with anyone without your written permission. Many clients choose me as their therapist because they know me through group situations or are sent to me by another client as a referral. Some clients may know each other. Consequently you may bump into someone you know in the waiting room. Also, while dual relationships can enhance therapeutic effectiveness, they can also detract from it; and, often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to me if the dual relationship becomes uncomfortable for you. I will always listen carefully and respond accordingly to your feedback. I will discontinue the dual relationship if I find it interfering with the effectiveness of the therapeutic process or your welfare; and, of course, you can do the same at any time.

CANCELLATION: You are responsible for remembering the date, location, and time of appointments. Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the **full fee** will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

INITIALS_____

Dr. Lewis James Jordan, PhD, LMHC, NCC

I have read the above Office Policies and Informed Consent Agreement carefully. I understand them and agree to comply with them.

Client name (print)	Date	Signature

Client name (print)	Date	Signature

Dr. Lewis James Jordan, PhD, LMHC

	Date	Signature

Dr. Lewis James Jordan, PhD, LMHC
MH 9760

CLIENT INFORMATION FORM

Name: _____ Date of Birth _____

Address: _____ Marital Status _____

_____

Home Phone #: _____ Safe to call? Y N Cell Phone #:_____

Employer: _____ Occupation:_____

Work Phone #: _____ OK to call? Y N

E-Mail: _____

Emergency Contact:

Name: _____ Relationship to you _____

Address: _____

_____

Phone #: _____ Other Phone #: _____

Please state in your own words your reason for seeking Therapy:

_____

_____

_____

Please check any areas where you are experiencing challenges:

Grief, death, illness	___	Financial stressors	___	Legal issues	___
Work, profession	___	Family stressors	___	Health, sleep, physical challenges	___
School	___	Change in residence	___	Other loss: _____	___
Relationships	___	Loss / promotion of a job	___	Other big change: _____	___
Marriage, separation, divorce	___	Pregnancy, miscarriage birth, abortion	___	Other _____	___

Have you experienced any of the following in the past year?

Fatigue	___	Mood swings	___	Isolation / loneliness	___
Intrusive thoughts	___	Decreased concentration	___	Loss of interest in daily activities	___
Panic / anxiety	___	Memory loss	___	Feelings of guilt, worthlessness	___
Depression	___	Weight gain / loss	___	Other: _____	__
Physical violence	____	Sleep disturbances	____	Other _____	____

What role (if any) does spirituality or religion play in your life? _____

How will you know when you overcome your challenges? What will be different? _____

Please answer the following questions and keep the answers fresh in your mind for your first visit with Dr. Jordan. You may also read about this section that Dr. Jordan calls The God Test, on Dr. Jordan's website at www.JordanTherapy.com and click on "The God Test." This test is not used for religious purposes but as a psychological tool.

1. When you think something is not fair, you are most likely to blame it on:

A. God **B.** A persons choice **C.** Bad Luck or Fate **D.** Karma **E.** I Don't know

2. When someone asks you why something bad is happening to them, you would most tell them that it is:

A. God **B.** A persons choice **C.** Bad Luck or Fate **D.** Karma **E.** I Don't know

3. A plane crashed into the World Trade Towers on 9/11 and you are in the 98th floor and die. Who's to blame:

A. God **B.** A persons choice **C.** Bad Luck or Fate **D.** Karma **E.** I Don't know

Relationships:

Relationship / Marital History (Give names, Ages & Duration):_____

_____

_____

Children (Give names & DOB): _____

_____

Parents and Siblings (Give names & DOB):

_____

_____

Support Systems:

Coping Skills / Self Care: _____

_____

_____

Education / Degrees: _____

_____

Friendships: _____

_____

Work / Hobbies / Interests: _____

_____

Dr. Lewis James Jordan, PhD, LMHC
MH 9760

Medical & Mental Health History:

Medical History: _____

_____

Current MD: _____ Date of Last Visit: _____

Current Psychiatrist: _____ Date of Last Visit: _____

Current Medications & Dosages: _____

_____

Previous Therapist: _____ Date of Last Visit: _____

Previous Therapy for: _____

Dr. Lewis James Jordan, PhD, LMHC
MH 9760

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Client Name(s) (print): _____ _____

Federal regulations (HIPAA) allow me as your service-provider to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The *Notice of Privacy Practices* leaflet describes these disclosures in more detail. You have the right to review the *Notice of Privacy Practices* before signing this consent.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions.
If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken regarding the PHI prior to the date of revocation.

This consent is voluntary; you may refuse to sign it. However, I reserve the right to deny treatment if this consent is not granted, or if the consent is later revoked.

I (client) hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Client/Parent/Guardian: _____Date: _____

Signature of Client/Parent/Guardian: _____Date: _____

ACKNOWLEDGMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

By signing this section, you (the client) acknowledge receipt of the *Notice of Privacy Practices* leaflet that I have given to you. The *Notice of Privacy Practices* provides information about how I may use and disclose your protected
health information (PHI). I encourage you to read it in full. If you have any questions about the *Notice*, please contact me.

A current copy of *Notice* may be obtained by contacting me at:

398 Camino Gardens Boulevard Suite 101 Boca Raton, FL 33432 or by calling 561-347-5099

I (client) acknowledge receipt of the *Notice of Privacy Practices* from Dr. Lewis Jordan, PhD, LMHC.

Signature of Client/Parent/Guardian: _____Date: _____

Signature of Client/Parent/Guardian: _____ Date: _____