TRINITY ESCAPE, LLC
Counseling, Coaching & Consulting

COUNSELING AND FINANCIAL AGREEMENT

As we serve you here at Trinity Escape, LLC we ask you to be aware of the following policies. By signing this form, you agree to have accountability concerning each one of them. Our counselors are licensed mental health therapists by the State of Florida. If you have questions, please talk to your Intake worker or Counselor.

- I hereby grant permission for any therapy, groups or diagnostic evaluations that may be deemed pertinent in the counseling process. The therapy sessions and records are strictly confidential except where state law requires the reporting of the following: threats of violence or harm, child, elder or handicapped abuse and neglect or if I sign a release form for Trinity Escape, LLC to divulge any or all information.
- Being aware that there may be potential for emotional strains, stresses, and life changes as a result of therapy, I enter the therapy process understanding that Trinity Escape, LLC does not guarantee any particular results or outcome from the therapy process.
- I am aware that services are limited to mental health issues.
- I am aware that Trinity Escape, LLC is not an emergency service. I am aware that in an emergency situation (emotionally distressed/suicidal/hurting someone else) I should call 911 or my primary care physician. Trinity Escape, LLC does not offer an on call service.

FINANCIAL POLICY

Fee Schedule:

$115.00	***Intake Session 50 minutes – First office visit***
$115.00 – 150.00	***Licensure Level Counseling 50 - 60 minutes***
$115.00	***Pre-Marital Counseling 60 minutes***
$115.00	***Skype or Phone Counseling 50 - 60 minutes***
$225.00	***Psychosocial Assessment***
$225.00	***Substance Abuse Evaluation***
$125.00	***Anger Management 1hour = 2 hour credit***
$65.00	***Anger Management per 30 minutes***

We need your support as a client to meet all financial obligations to Trinity Escape, LLC. *Our counselors are ONLY paid for services as their clients pay.* No one attempting to be fiscally responsible will be denied services. Payment with cash, check, or credit/debit cards is due at time of service. At our office, we accept Visa, Mastercard, and Discover. Discussions between counselors and clients are encouraged when financial challenges occur. PAYMENT IS DUE UPON SERVICES RENDERED.

CANCELLATION POLICY

If you do not receive a reminder call please keep in mind the reminder is a courtesy only. To better serve you as a client and out of respect to the Counselors and other scheduled clients, a 24-hour notice is expected for a cancellation. If this notice is not given, a cancellation fee of $55.00 will be billed to the client's account. Except for emergency situations, those who fail to cancel and are a no-show will also be billed a $55.00 fee or credit card on file will be charged if applicable. If the office is not open and you need to cancel, you may leave a message on our voice mail. Thank you for your help in this matter.

Client Signature/Date **Client Signature/Date**

Counselor Signature **Parent/Legal Guardian Signature (If applicable)**

TRINITY ESCAPE, LLC
Counseling, Coaching & Consulting

Child & Adolescent Intake Form

Child's Name: _____ Date of Birth_____

Address_____SSN_____

City, State, Zip_____

Last grade completed in school_____ Grade Average_____

Father: _____ Date of Birth_____

Address_____SSN_____

City, State, Zip_____ Highest Grade Completed_____

Occupation_____ Place of Employment_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Religious Affiliation_____

Mother: _____ Date of Birth_____

Address_____SSN_____

City, State, Zip_____ Highest Grade Completed_____

Occupation_____ Place of Employment_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Religious Affiliation_____

Step-Parent/Other Guardian: _____ Date of Birth_____

Address_____SSN_____

City, State, Zip_____ Highest Grade Completed_____

Occupation_____ Place of Employment_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Religious Affiliation_____

Presenting Problems: _____

_____

_____

_____

What languages are spoken at home? _____

How many homes has the child lived in? _____

With whom does the child share a bedroom and/or bed? _____

Who cares for the child during the day? _____

In what year were the natural parents married? _____

How many years were parents married before birth or adoption of 1st child? _____

In what year were the parents separated, if applicable? _____

Who has legal custody of the child? _____

Are you authorized to seek counseling for this child? ○ yes ○ no

In what year was the custodial parent remarried, if applicable? _____

This child is: ○ adopted ○ natural

List any known problems encountered during this pregnancy _____

What was child's birth weight? _____ Were eating/sleeping patterns ○ regular ○ irregular

What was child's approach to new situations: ○ Positive ○ Withdrawn ○ Slow to warm up

What was child's reaction to new stimuli? ○ Intense ○ Moderate ○ Little/None

When trying new things or encountering new situations, regardless of child's initial reaction, would you describe your child as ○ Adaptable ○ Slow to adapt ○ Inadaptable

What age was toilet training started? _____ What age was it established? _____

Describe any struggles, if any, with toilet training _____

Does the child ever wet the bed? ○ Yes ○ No How often? _____

Does the child wet primarily during the ○ Night ○ Day ○ Both

Does the child ever soil? ○ Yes ○ No Where is the child usually when soiling or wetting occurs?

_____

How is discipline handled in the home? _____

_____

_____

Describe any traumatic events the child has been through (deaths, abuse, moves, etc) _____

_____

_____

_____

List child's interest/hobbies/skills: _____

_____

_____

Is child attending school? ◯ Yes ◯ No Is child expected to ◯ Pass ◯ Fail this year?

What special services, if any, is the child receiving in school? In what subjects and for how many hours per day? _____

Is the child presently receiving counseling in the school? ◯ Yes ◯ No

If yes, from whom? _____ Phone # _____ May we contact Him/her? ◯ Yes ◯ No Has the child ever failed a class or been held back? ◯ Yes ◯ No

If yes, describe _____

Past Consultations: Sources of help sought in the past (Psychologists, psychiatrists, etc.) _____

_____

_____

Please list any additional information you feel we should know about _____

_____

_____

_____

Trinity Escape, LLC
COUNSELING, COACHING & CONSULTING

CONSENT TO TEST, COUNSEL AND CONDUCT THERAPY WITH A MINOR

I, the undersigned, do hereby give my consent and permission for Trinity Escape, LLC, to test, counsel, and/or conduct therapy with the child or children listed below:

_____

_____

I further grant permission for Michael Castrilli and Trinity Escape, LLC to share information concerning those listed above with other professionals. I also understand that strict confidentiality will be maintained with the exception of endangerment of life welfare, or as otherwise provided by law.

I also certify that I am the parent, guardian, or managing conservator of those listed above and that I am legally empowered to give this consent.

_____

PRINT NAME

_____

PARENT(S) SIGNATURE

_____

DATE

Trinity Escape, LLC
Counseling, Coaching & Consulting

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, do hereby authorize Trinity Escape, LLC and counselor(s) and/or staff to receive from/disclose to:

Contact /Organization Name & Relationship: _____

Address: _____

Phone: _____Fax: _____

Contact /Organization Name & Relationship: _____

Address: _____

Phone: _____Fax: _____

Contact /Organization Name & Relationship: _____

Address: _____

Phone: _____Fax: _____

Contact /Organization Name & Relationship: _____

Address: _____

Phone: _____Fax: _____

I understand that under state and federal confidentiality provisions only the above specified information can be released to the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify (in person or in writing) Trinity Escape, LLC.

_____

CLIENT SIGNATURE **DATE**

_____

CLIENT SIGNATURE **DATE**

Trinity Escape, LLC
Counseling, Coaching & Consulting

E-MAIL AND/OR TEXT COMMUNICATIONS CONSENT

I _____ allow Trinity Escape, LLC Counseling & Coaching Services to use electronic mail (e-mail) and/or text messaging to communicate coaching/counseling/administration information to me pertaining to services that I have received. I acknowledge and understand that e-mail communication may contain my personal and private information including, but not limited to, my name, address, types and dates of services received etc… I understand that, although Trinity Escape, LLC Counseling & Coaching Services may attempt to protect the privacy of the contents of e-mail sent to me and will take reasonable measures to protect my privacy, ***the e-mail messages sent to me are not encrypted and travel over the Internet. As a result, there is a risk that the e-mail will be intercepted and read by unauthorized third parties.*** In allowing Trinity Escape, LLC Counseling & Coaching Services to send me e-mail, I assume this risk.

I acknowledge and understand the following as it relates to this e-mail/text communication:

- E-mail/text is not appropriate for conveying information relating to emergency matters.
- If an e-mail/text has not been answered, I may make an appointment to see/speak with Trinity Escape, LLC Counseling & Coaching Services to discuss the e-mail message.
- I, and not Trinity Escape, LLC Counseling & Coaching Services, am responsible for the security of e-mail/text communications sent from or stored on my computer.
- My decision to allow Trinity Escape, LLC Counseling & Coaching Services to communicate with me by e-mail/text is voluntary, and treatment is not conditioned upon my election to do so.
- Trinity Escape, LLC Counseling & Coaching Services or I may stop e-mail/text communication at any time for any reason.
- I agree to notify Trinity Escape, LLC Counseling & Coaching Services when my e-mail address/phone number changes.
- I will not hold Trinity Escape, LLC Counseling & Coaching Services responsible for damages resulting from their use of e-mail or the failure of any Trinity Escape, LLC Counseling & Coaching Services information systems used to facilitate the e-mail communication.

Trinity Escape, LLC Counseling & Coaching Services may communicate via email to the <u>designated individual</u> listed below:

CLIENT'S NAME (PRINT) **CLIENT'S SIGNATURE**

EMAIL ADDRESS **DATE**

CLIENT'S NAME (PRINT) **CLIENT'S SIGNATURE**

EMAIL ADDRESS **DATE**

TRINITY ESCAPE, LLC
COUNSELING, COACHING & CONSULTING

CLIENTS ACKNOWLEDGEMENT
REGARDING RETURNED CHECKS

Under Florida law, any checks returned "NSF" (non-sufficient funds), "Account Not Found" or "NSF Unless Otherwise Indicated is a worthless check subject to prosecution under Florida's criminal statutes. We at Trinity Escape want to be fair regarding NSF checks. Therefore, the bank charges us a fee each time a check is returned to the bank regardless of the reason. If you have a returned check, you will be charged a **$40.00 non - sufficient fund fee** that will be accessed to your account.

After two returned checks, you agree to pay for services by cash or money order only.

IF YOU WILL BE WRTING CHECKS FOR YOUR VISIT: PLEASE PROVIDE YOUR DRIVERS LICENSE INFORMATION BELOW:

PRINT NAME:_____

DL # _____

EXP. _____ STATE ISSUED _____

_____

CLIENT SIGNATURE **DATE**

TRINITY ESCAPE, LLC
COUNSELING, COACHING & CONSULTING

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

For more information Trinity Escape, LLC has provided the following website at www.hhs.gov

CLIENT NAME: _____

RELATIONSHIP TO CLIENT: _____

SIGNATURE: _____

DATE: _____

TRINITY ESCAPE, LLC
COUNSELING, COACHING & CONSULTING

CONFIDENTIALITY
RE: SUBPOENA OF RECORDS

This document assures that I the undersigned agree as a condition of the underlying therapist, Michael D. Castrilli and the staff of Trinity Escape, LLC Counseling and Coaching Services provision of mental health services. I will not call my therapist to testify, to produce records, affidavits, reports, or connections with any legal proceedings for minor child or myself. Nor will I allow any of my legal representatives to do so either.

Conversations and communications will be considered by my legal representative and I to be confidential/privileged material and will not be the subject of discovery in any proceedings by means of depositions, subpoenas, or otherwise, unless court ordered by a judge.

IF THIS AGREEMENT IS BROKEN BY THE UNDERSIGN, THERE WILL BE A $300.00 HOURLY RATE INCORPORATED INTO THE ABOVE FOR ANY OF THE COUNSELOR(S) TIME.

_____

***CLIENT SIGNATURE** **DATE**

_____

SIGNATURE OF WITNESS **DATE**

****PLEASE NOTE: TO BE SIGNED IN FRONT OF A TRINITY ESCAPE, LLC REPRESENTATIVE***