# 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:*** | ***$120.00*** | ***Intake Session 50 minutes – First office visit*** |
| | ***$120.00 – 150.00*** | ***Licensure Level Counseling 50 - 60 minutes*** |
| | ***$120.00*** | ***Pre-Marital Counseling 60 minutes*** |
| | ***$120.00*** | ***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**
# ADULT INTAKE FORM

## GENERAL INFORMATION

*Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.*

Name:_____ Today's Date:_____

Your age: _____ Date of Birth (DOB):_____

Address:_____

_____

Spouse or Partner's Name (if applicable): _____

Home phone:_____ May I leave a message? ◯Yes ◯No

Cell phone:_____ May I leave a message? ◯Yes ◯No

Work phone:_____ May I leave a message? ◯Yes ◯No

Email: _____ May I email you? ◯Yes ◯No

Who referred you to our center? _____

_____

In case of emergency, whom can we contact? _____ Relationship to you _____

_____

## CURRENT FAMILY, OCCUPATION

### Relationships

Are you currently married? ◯Yes ◯No, How long? _____

Are you currently partnered/in a romantic relationship? ◯Yes ◯No, How long? _____

Are you currently separated or divorced? ◯Yes ◯No How long? _____

If you and your former spouse/partner have children together, please describe your current custody & visitation schedule (if any) and the status of your communication: _____

_____

### Children

Please list your biological, adopted and/or stepchildren (if applicable)

| First name | Biological, Adopted or Step | Current Age | School grade? | Male/ Female | Lives with you? (Yes/No) | Describe your relationship in a few words |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Employment and/or Current Educational Situation**

Are you currently employed? Yes No Place of employment:_____

Are you currently a student? Yes No If yes, where_____

High School_____ College_____ Professional Education_____

**CURRENT MEDICAL AND MENTAL HEALTH**

How much are <u>each</u> of the following areas currently a problem for you?

| | **Not at all** **1** | **A little** **2** | **Somewhat** **3** | **Considerably** **4** | **Terribly** **5** |
|---|---|---|---|---|---|
| Anxiety | 1 ◉ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Physical Problems | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Sleep Problems | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Depression | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Alcohol or Substance Abuse | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Family Conflicts | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Marital Conflicts | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Social Relationships | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Job/School | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Sexual Problems | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Spiritual/religious | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Legal Problems | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Eating Disorder/Struggles | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |
| Abuse (physical, emotional, sexual) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ |

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many meetings did you have? Was the experience helpful or not? How so?

_____

_____

Please list all <u>current</u> prescription medications and how often you take them (psychiatric and general health):

Medication Name: Total Daily Dosage: Estimated Start Date:

_____

_____

_____

_____

_____

Please list any <u>previous</u> psychiatric medications (with dosage and dates): _____

_____

Do you currently have any medical problems? _____

_____

Have you ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

_____

_____

Who is your primary care physician? _____

Who is your psychiatrist (if applicable)? _____

**FAMILY MENTAL HEALTH HISTORY**

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

| | Please circle | List Family Member(s) |
|---|---|---|
| Anxiety (general) | ◯Yes ◯No | |
| Obsessive Compulsive Behavior | ◯Yes ◯No | |
| Depression | ◯Yes ◯No | |
| Suicide Attempts | ◯Yes ◯No | |
| Bipolar/Manic Depressive | ◯Yes ◯No | |
| Alcoholism | ◯Yes ◯No | |
| Substance Abuse | ◯Yes ◯No | |
| Domestic Violence | ◯Yes ◯No | |
| Eating Disorders | ◯Yes ◯No | |
| Obesity | ◯Yes ◯No | |
| Schizophrenia | ◯Yes ◯No | |
| Counseling or Psychotherapy | ◯Yes ◯No | |
| Psychiatric Hospitalizations | ◯Yes ◯No | |

Do you consider yourself spiritual or religious? ◯Yes ◯No

Is so, describe your spirituality/faith and your level of participation in a faith-based group (if applicable) :____

_____

Have you experienced any unusually severe stresses during the last year? ◯Yes ◯No
If yes, please describe:_____

_____

What do you consider to be your strengths?_____

What do you consider to be your areas of needed growth?_____

Is there any other information you'd like to add? _____

_____

# 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.

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**Trinity Escape, LLC Counseling & Coaching Services may communicate via email to the designated individual 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***