Howard Lane, LMHC
12651 West Sunrise Boulevard, Suite 101
Sunrise, Florida 33323
Phone: 954-850-2945

Contact Information Sheet

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female
Name: _____
Address: _____
(Street and Number)
_____
(City) (State) (Zip)
Home Phone: (_____) May we leave a message? □ Yes □ No
Cell/Other Phone: (_____) May we leave a message? □ Yes □ No
E-mail: _____
May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact:

Name: _____Relationship:_____
Phone number:_____

Occupation:_____
Place of Employment: _____
Work number:_____ If needed, is it ok to call here?_____

Howard Lane, LMHC
Policies

Please note that payments are due upon receiving services. We require a 24-hour notice of cancellation of appointments to avoid being charged a missed appointment fee for the full amount of your session. Repeated cancellation of appointments and/or failure to comply with treatment recommendations is counterproductive and may result in termination of your treatment with the option of referral to another treatment source.

Checks returned for insufficient funds will be subject to a fee of fifty ($50.00) administration fee above and beyond the bank's penalty fee. If such an event occurs more than once, you will be asked to make payment in cash or money order.

Sessions are an average of 45 to 50 minutes in length.

Text messaging is not considered a secure means of communication. Text messaging for issues other than changing an appointment or providing an update are not encouraged and will incur a cost of $.50 a text message or $25 for a quarter of an hour.

Our practice is on several social media platforms. Our therapists will not directly engage you on social media. Our therapists will not friend you on Facebook or any other social media platform where personal information is exchanged. You may decide to follow us on our social media. We will never identify you as a client.

I hereby certify that I understand the above and have been informed of service policies and procedures. Furthermore, I authorize Howard Lane, LMHC and HowardLaneRecovery.com _____ to render necessary treatment and to file appropriate insurance claims for this treatment if necessary. If I do not have insurance, I agree to pay for services as they are rendered.

_____ _____

Signature of client/parent/parents **Date**

HowardLaneRecovery.com
Email: Howard@HowardLaneRecovery.com

Patient Consent for Use and Disclosure

of Protected Health Information

I hereby give my consent for **Howard Lane, LMHC and HowardLaneRecovery.com** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Howard Lane, LMHC and HowardLaneRecovery.com describes** such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Howard Lane, LMHC and HowardLaneRecovery.com** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to**. Howard Lane, LMHC and HowardLaneRecovery.com,**
12651 West Sunrise Boulevard, Suite 101
Sunrise, Florida 33323

With this consent, **Howard Lane, LMHC and HowardLaneRecovery.com** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Howard Lane, LMHC and HowardLaneRecovery.com** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Howard Lane, LMHC and HowardLaneRecovery.com** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Howard Lane, LMHC and HowardLaneRecovery.com** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Howard Lane, LMHC and HowardLaneRecovery.com** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Howard Lane, LMHC and HowardLaneRecovery.com** may decline to provide treatment to me.

Patient Consent for Use and Disclosure

of Protected Health Information (Continued) pg. 2

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name **Date**

_____

Print Name of Patient or Legal Guardian, if applicable

Limits of Confidentiality

Psychotherapy is confidential, with the below stated exceptions.

Duty to Warn: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

Suicide/Self harm: Depression is common emotion expressed in therapy, but if a client is feeling hopeless enough to imply or disclose a plan for suicide; steps need to be taken to ensure safety.

This would include notifying the legal authorities as well as make reasonable attempts to notify the family.

Animal abuse: I will report animal abuse, including cases of neglect and hoarding.

Vulnerable Adults and Children: Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies and/or legal authorities.

Prenatal Exposure to Controlled Substances: in keeping with protecting vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Minors/Guardianship: Parents or legal guardians have the right to access a minor client's health information; however, substance abuse information is protected. Age of adult for psychotherapy is -___18___.

Insurance Providers: Information requested includes description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, prognosis for improvement, case notes and summaries.

I have read and understand the above-stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above-stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information, I understand that I will be provided a Release of Information form.

Client name: _____

Parent Signature: _____Date:_____

HowardLaneRecovery.com
Email: Howard@HowardLaneRecovery.com

Intake Form

Date of first appointment: _____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:
□ Medical Provider: _____
□ Insurance Provider: _____
□ Website
□ Psychology Today website
□ Friend/Family: _____

Have you previously received any type of mental health services? □ No □ Yes

If yes, which of the following:
□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization

Please provide:
Name of provider or facility:
_____
Location:
_____
Dates of treatment:
_____
Reason for treatment:
_____

Briefly, what brings you in today?

When did your problem first start? Within the last:
□ 30 days □ 6-12 months □ 2 years □ During adolescence □ During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

Family History

Where were you born?_____

Where did you grow up?

_____

□ city □ suburbs □ country

Please list your parents and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they now live?	If deceased, age and cause of death

Who did you live with, growing up?

_____

Mother's occupation:

_____

Father's occupation:

_____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:
□ Never Married
□ Domestic Partner □ Married For how long?_____ Please give partners name:
_____
On a scale of 1-10 (best), how would you rate your relationship? _____

□ Separated □ Divorced For how long?
_____
□ Widowed: please give partners name, and year deceased: _____

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

Prescribing provider and contact information:
Name:
_____

Specialty:
_____

Facility:
_____

Phone, email, or Fax:
_____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep: staying asleep awakening early sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

Please list any difficulties you experience with your appetite or eating patterns:

_____

Any change in weight over the past year? □ No □ Yes:

_____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe

_____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

HowardLaneRecovery.com
Email: Howard@HowardLaneRecovery.com

Credit card authorization

I, _____ authorize: Howard Lane, LMHC and/or its assigns

to charge my _____ card account number _____

verification code (3 digits) _____ expiration date _____ in the amount of

_____ for therapy sessions, full fee for cancellations, and $125 per hour for all

court related services.

____(initials) I understand that sessions cancelled without 24 hours' notice and/or any no-show will be billed for the above amount as agreed in the Policies and Procedures.

____(initials) Phone sessions, emergency phone calls can also be charged to my authorized credit card.

____(initials) Returned checks will be subject to an additional fee of $50.00 which must be paid within 30 days and must be paid by cash or money order to Howard Lane

____(initials) Outstanding balances beyond 30 days having received a written notice are subject to a $20.00 administrative fee being added to their account balance every 30 days due to administrative costs. Outstanding balances beyond 60 days (having not made payment arrangements with Howard Lane, LMHC) are subject to their account being forwarded to an outside collection agency.

Signature: _____ Date: _____
Zip code _____House #_____
This form will remain in a locked cabinet and will be shredded upon termination of services.