



6938 West Linebaugh Avenue  
 Suite 101  
 Tampa, FL 33625  
 (443) 621-0976

**Identifying Information**

Client Last Name:	First:	Middle:	Gender	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced
Street Address:			Birth Date	Age
Zip Code:	City:	State:	Ethnicity	Phone Number

Employer/School
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**Emergency Contact Information**

Emergency Contact Name:	Relationship to Client
Street Address:	Phone Number
Zip Code:	City: State:

**Other Treatment Providers Information**

Provider Name:	Provider Type:	Phone Number:
Provider Name:	Provider Type:	Phone Number:

How did you hear about us? \_\_\_\_\_



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### Client Symptom Report

Chief Complaint:

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Current Diagnosis:

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Current Medications:

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Previous Psychiatric Hospitalizations:

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### Symptom Checklist

	Depression		Little Enjoyment in Hobbies	Excessive Alcohol Use
	Low Energy		Isolation/Withdrawal	Drug Use
	Sadness		Feeling Irritable/Agitated	Promiscuity
	Hopelessness		Anger Outbursts	Absence from Work/School
	Helplessness		Impulsivity	History of Trauma/Abuse
	Difficulty Concentrating		Physically Attacking Others	Flashbacks
	Difficulty Falling Asleep		Verbally Attacking Others	Fear of Abandonment
	Difficulty Staying Asleep		Anxiety or Worry	Suicidal Ideation
	Loss of Appetite		Panic Attacks	Thoughts of Self-Harm
	Increase in Appetite		Obsessions & Compulsions	Acts of Self-Harm
	Preoccupation with Weight		Perfectionism	Hallucinations



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**Financial Agreement**

Tampa Bay DBT is a fee for service company. All fees are due and collected at the time of service. We accept cash, checks, and credit cards. If you would like to leave a credit card on file for ongoing charges you can complete the credit card authorization form. We require 24 hours notice for all cancellations. If you do not provide 24 hours notice the full fee will be assessed.

The initial 90-minute assessment fee is \$200. A sliding scale is provided for ongoing individual therapy that is based on the experience level of your clinician.

Clinician Status	Fee	45-60 Minute Session
Senior Clinician	Full Fee	\$175
Staff Clinician	Level 1	\$110
Registered Post-Grad Intern	Level 2	\$60
Graduate Student Intern	Level 3	\$10

Group Fee: \$50

Tampa Bay DBT is considered out of network with insurance companies. We will make our best effort to assist you in utilizing your insurance benefits when possible. You can contact your insurance company to check the out of network benefits provided with your policy. Our services can be applied towards your deductible. At times, clients have been able to arrange a single case agreement with their insurer. Please speak with your clinician directly about the possibility of arranging a single case agreement. For those individuals who arrange a single case agreement, payment in full is due at the time of service. A detailed statement will be provided upon request.

I \_\_\_\_\_ understand that Tampa Bay DBT is a fee for service company and that payment is due at the time of service. By signing this agreement, I understand the fee for individual therapy is \$\_\_\_\_\_ and \$50 per group session. By signing this agreement, I am acknowledging that I have read and understand the cancellation policy.

\_\_\_\_\_  
Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



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### Cancelation Policy

We understand that there will be times that you will need to cancel or reschedule your individual or group counseling appointments. Please make your best effort to let us know when you have a scheduled appointment that you are unable to keep.

The full session fee will be charged for individual and group appointments that are cancelled inside of 24 hours of the appointment time. If a late cancellation fee is assessed and you do not have a credit card on file, the fee will be collected prior to or at the start of your next scheduled appointment.

Cancellations related to illness and emergencies will be handled on an individual basis.

By signing this policy, I am acknowledging that I am fully aware of the cancellation policy of Tampa Bay DBT.

\_\_\_\_\_  
Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



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### Credit Card Authorization Form

I give Tampa Bay DBT permission to charge my credit card for services provided. A copy of the receipt will remain on file and will be provided to me upon request. I am aware that the fee may change based on the services provided. I agree to pay \$\_\_\_\_\_ per 60-minute individual session and \$50 per group session. I understand that if I do not cancel my appointment within 24 hours of the scheduled time my card will be charged the full amount.

Tampa Bay DBT accepts Visa, Master Card, and American Express.

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Name of Card Holder: \_\_\_\_\_

Signature of Card Holder: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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### Informed Consent

**In the state of Florida, the age of consent for outpatient mental health services is 14 years old. This means that any individual seeking services 14 years and older must complete the following information. Additionally, in accordance with the Health Insurance Portability and Accountability Act, any individual 14 years or older must complete a consent form in order for us to release any information regarding their care. This includes parents, primary custodians, and other family members.**

Please check each line item indicating you have read and understand it.

- I am a competent adult voluntarily seeking mental health assessment and/or counseling for myself and/or my minor child (13 years and under).
- I understand that although treatment is expected to be helpful in resolving my problems, no guarantee has been made about the usefulness or effectiveness of treatment by Tampa Bay DBT. I do hereby absolve Tampa Bay DBT from any liability in the event its treatment of my person is unsuccessful either in the short or long term.
- I understand that advanced notice of 24 hours is required if I am unable to attend my appointment to avoid the fee for the appointment.
- I understand that Tampa Bay DBT counselors are not in network with any insurance companies. Fees are due at the time of service, and I will be provided with a bill to submit to my insurance company upon request.
- I understand that if I miss 4 consecutive sessions in a row, I have dropped out of treatment and will have to complete an initial assessment in order to return to treatment.
- I understand that every effort will be made to protect the confidentiality of my medical records according to the Health Insurance Portability and Accountability Act guidelines and regulations. I understand that the laws of this state and the guidelines of the clinician's code of ethics allow the following exceptions to confidentiality, which are legally required, and will be followed by Tampa Bay DBT.
  - All information will be held confidential and privileged unless the clinician has reason to believe that I may have neglected or abused a child, senior citizen, or a disabled person. In such cases a report will be made as required by law to the appropriate law enforcement and social welfare agencies.
  - All information will be held confidential and privileged unless I report suicidal or homicidal ideation, intent, or plan. In such cases a report will be made as required by law to the appropriate law enforcement and social welfare agencies so that treatment to protect the safety of myself and others may be provided.



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- I understand that my clinician participates on a DBT consultation team as a part of my treatment. I understand that my information will be shared and discussed with the other clinicians within Tampa Bay DBT and outside of Tampa Bay DBT that participate on this consultation team. I understand that the consultation team is bound to the regulations of the Health Insurance Portability and Accountability Act guidelines and regulations.
  - I agree to receive confidential telephone calls or messages from Tampa Bay DBT to the telephone numbers I have provided. I understand that if I chose to use texting as a method of communication with Tampa Bay DBT that there is no guarantee that these messages can be kept confidential.
  - I agree to receive confidential mailing from Tampa Bay DBT to the home address I have provided.
  - I understand that Tampa Bay DBT utilizes Gmail and that there is no guarantee that email communications will remain confidential.
  - I have received a copy of the Notice of Privacy Practices adhered to by Tampa Bay DBT.

\_\_\_\_\_  
Signature of Client/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

### Notice of Privacy Practices



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**This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.**

Information regarding your health care, including drug and alcohol treatment, is protected by two federal laws: The Health Insurance Portability and Accountability Act (HIPAA) and the Drug and Alcohol Treatment Confidentiality Law. Under these laws, Tampa Bay DBT may not disclose any information identifying you as receiving alcohol or drug treatment, or disclose any other protected information, except as permitted by law.

This notice tells you how Tampa Bay DBT protects the confidentiality of your protected health information. Protected health information is any individually identifiable information including our name, address, telephone and/or fax number, electronic email address, social security number, or other identification number, date of birth, and dates of treatment. We follow the privacy practices that are described in this notice.

Any individual authorized to enter information into your medical records and any individual who may need access to your information must abide by this notice. All subsidiaries, business associates, sites and locations of Tampa Bay DBT may share information with each other for treatment purposes of health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish this task will be shared.

The following categories describe different ways that Tampa Bay DBT may use and disclose medical information without your specific request or written authorization. Examples are provided for each category of uses or disclosure. Not every possible use or disclosure in a category has been listed.

1. **Treatment:** We may use medical information about you to provide you with medical treatment services. Examples include in treating you for a specific condition we may need to know if you have other conditions that may affect your treatment.
2. **Payment:** We may use and disclose medical information about you so that the treatment and services you receive from Tampa Bay DBT may be billed and payment may be collected from you. Examples include we may need to send your protected health information, such as your name, address, office visit date, and diagnostic codes to our billing service for processing.
3. **Health Care Operations:** We may use and disclose medical information about you to health care operations to ensure that you receive quality care. Examples include we may use medical information to review our treatment and services and evaluate the performance of our clinicians in caring for you.



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The following include other ways your protected health information may be disclosed without your consent.

1. As required during an investigation by law enforcement agencies.
2. To avert a serious threat to public health or safety.
3. As required by military command authorities for their medical records.
4. To worker's compensation or similar programs for processing claims.
5. In response to a legal proceeding.
6. To a coroner or medical examiner for identification of a body.
7. To a correctional institution or a law enforcement official where you are an inmate.
8. As required by the US Food and Drug Administration.

We may contact you to provide appointment reminder or for information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The following outlines when disclosures of protected health information require your written consent.

All other uses and disclosure of protect health information not covered by this notice or the laws that apply to this practice will be made only with your written authorization. All authorizations are good for one year, unless your revoke that authorization in writing. You may revoke authorization to disclose protected health information at any time in writing. If you revoke your authorization, we will thereafter no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to maintain record of the care we have provided you.

**Any individual receiving serves with Tampa Bay DBT is considered a consenting adult. Therefore they must complete a written consent for clinicians to be able to disclose information about their treatment with family members, including adolescent parents.**

### **Patient Responsibilities**



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1. You have the responsibility to respect others regardless of their race, religion, age, gender, or disability.
2. You have the responsibility to provide accurate and complete information about present and past illnesses, hospital admissions, medications, advanced directives, and other matters pertaining to your healthcare.
3. You have the responsibility to keep your appointments and to arrive on time.
4. You have the responsibility to discuss difference of opinion regarding your treatment with your clinician.
5. You have the responsibility to comply with reasonable expectations regarding your treatment with your clinician.
6. You have the responsibility to keep confidential all clinical and personal information communicated to you in individual sessions or in groups by any person receiving or providing treatment.
7. You have the responsibility to refrain from bringing illicit drugs, alcohol, weapons, or other hazardous materials to the office premises of Tampa Bay DBT.
8. You have the responsibility not to come to individual or group sessions under the influence of drugs or alcohol.
9. You have the responsibility to participate in program activities to the best of your ability.

## **Patient Rights**



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All individuals who apply for services regardless of gender, race, age, ethnicity, gender identity, sexual orientation, financial status, or national origin as assured that their lawful rights as patients shall be guaranteed and protected. While receiving treatment with Tampa Bay DBT, you are assured and guaranteed the following rights:

1. To be treated with respect and dignity.
2. To receive timely treatment by qualified professionals. Every effort will be made to use the least restrictive, most appropriate treatment available, based on individual needs. An individualized treatment plan will be developed for each individual.
3. To receive quality treatment that is best suited to individual needs.
4. To express by signature an informed consent to the right to release information for communication purposes with other individuals or treatment providers.
5. To privacy for counseling sessions.
6. To request aid in communication if you are not proficient in English or if you have difficulty hearing and communicate using sign language.
7. To practice and express religious or cultural values unless doing so will interfere with others; treatment or will harm others in any way.
8. To be provided with a safe environment.
9. To exercise your constitutional, statutory, and civil rights.
10. To be provided services in accordance with standards of practice, appropriate to your needs, and designed to afford a reasonable opportunity to improve your condition.
11. To know any policies and procedures and how they apply to your conduct as a patient.
12. To obtain information about your condition, proposed treatment, the potential benefits and drawbacks of the proposed treatment, problems related to recovery and your prognosis from your clinician.
13. To obtain information about alternative treatment and alternative providers.
14. To report any abuse or neglect, whether you are a victim or an observer.
15. To refuse or terminate treatment.
16. To be informed of the options available to you when you finish treatment and to be provided with a specific plan outlining any recommended continuing care.

### **Acknowledgment of Receipt**



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I hereby acknowledge that I have received and reviewed a copy of Tampa Bay DBT policies informing me of the following:

1. Notice of Privacy Practices
2. Patient Rights
3. Patient Responsibilities
4. Consent to Treatment
5. Patient Rights Regarding Protected Health Information

\_\_\_\_\_  
Signature of Client/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship if not signed by Client

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date