Mid Florida Counseling, LLC

Kissimmee Office: 1400 W Oak Street, Suite G, Kissimmee, FL 34741
Orlando Office: 3222 Corrine Drive, Suite J, Orlando, FL 32803

Phone: 321-250-1054 Fax: 321-256-0307

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Neither verbal information nor written records about a client can be shared with another party without the written consent of the client or the client's legal guardian. Below are noted exceptions when the mental health professional is required to report information to the appropriate social service and/or legal authorities:

- **Duty to Warn and Protect -** When a client discloses intentions or a plan to harm him/herself or another person. In cases of report of plans of suicide, a reasonable effort will be made to notify emergency contact on record.
- **Abuse of Children and Vulnerable Adults -** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse.
- **Prenatal Exposure to Controlled Substances -** Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- **Insurance Providers** (when applicable) - If you are using insurance, insurance companies and other third-party payers may request information regarding services to clients including, dates of service, charges, symptoms, diagnosis, and treatment recommendations.

______(initials)

CANCELLATION POLICY

If you fail to cancel a scheduled appointment with at least 24 hours' notice, or fail to show, we cannot use this time for another client and you will be billed a fee of $30.00 for the missed appointment, unless it is due to a sudden illness or a **true** emergency. Arrival to an appointment more than 15 minutes late may result in a shortened session or cancellation and $30 fee. 3 or more cancellations for ANY reason within 6 month period, requires a $30 fee.

Note, appointment reminders are done as a courtesy and are not 100% reliable. If you do not get a reminder, you are STILL RESPONSIBLE for remembering the appointment and the above policy applies. Thank you for your consideration regarding this important matter.

______(initials)

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _________________ Name of Insurance Company(ies) and assign directly to Mid Florida Counseling, LLC all insurance benefits for psychotherapy services, if any; otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Mid Florida Counseling, LLC to release all information necessary to process the claims. I authorize the use of this signature on all insurance submissions.

____________________________________	________________
Client Signature (Client's Parent/Guardian if under 18)	Today's Date
________________________	____________________
Printed Name of above Signature	Email

CONF CANC & INSUR RELEASE