Breathing Space – Today, LLC.
Sandra Chmielewski, RMHCI
Mental Health Counseling
License #23886, EIN #92-2421160

Client Information & Psychosocial

Name: _____
(Last) (First) (Middle) (Preferred name)

Birth Date:_____/_____/_____ Age: _____ Gender: Male Female

Name of Parent/Guardian (if under 18 years old):

_____
(Last) (First) (Middle) (Preferred Name)

Mailing Address:_____
(number) (street name) (apt.#) (City) (State) (Zip Code)

Home Phone: _____ May we leave a message? Yes No
Cell/Other Phone:_____ May we leave a message? Yes No
May we communicate through text: Yes No

E-mail address:_____May we email you? Yes No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):_____
May I contact your referral source to thank them for the recommendation? Yes No

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc?) If yes, please explain your experience and diagnosis if one was given.

_____

_____

_____.

Are you currently taking any prescription medication(s)? If yes, please list names of medications, dosage and prescriber?

_____

_____

General Health and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

   Poor Unsatisfactory Satisfactory Good Very Good

2. How would you rate your current sleeping habits?

   Poor Unsatisfactory Satisfactory Good Very Good

3. How many times per week do you generally exercise? _____

4. Please list any difficulties you experience with your appetite or eating patterns?

   _____

5. Are you currently experiencing feelings of sadness, grief or depression? Please explain:

   _____

   _____

6. Are you currently experiencing extreme nervousness, anxiety or having panic attacks? Please explain.

   _____

   _____

7. Are you currently experiencing and/or being treated for chronic pain? Please explain

   _____

   _____

8. Do you use alcohol? If yes, please list types of alcohol and frequency of use.

   _____

9. Do you believe you could have a problem with alcohol? Yes No

10. Do you use drugs recreationally or otherwise? If yes, please list types of drugs and frequency of use.

    _____

11. Do you believe you could have a problem with drugs? Yes No

12. Do you believe you could have an unhealthy relationship with sex, shopping, gambling, exercise, food or any other behavior? If yes, please briefly explain. -

    _____.

13. Are you currently in a romantic relationship? If yes please indicate length of relationship and how you would describe your relationship. _____

14. Have you recently experienced significant life changes or stressful life events?

_____

_____

Family Mental Health History

Please 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.

			Relationship (ex. Mother)
• Alcohol/ Substance abuse	Yes	No	_____
• Anxiety	Yes	No	_____
• Depression	Yes	No	_____
• Domestic Violence	Yes	No	_____
• Eating Disorders	Yes	No	_____
• Obesity	Yes	No	_____
• Obsessive Compulsive Behavior	Yes	No	_____
• Schizophrenia	Yes	No	_____
• Suicide Attempts	Yes	No	_____

Developmental History

15. What was your birth order? I was the_____of_____children.
16. Who primarily raised you?_____.

17. How would you describe your childhood? Please circle one and briefly explain.

Traumatic Painful Uneventful Good Happy

_____

_____

_____

Additional Information

18. Do you have a legal history? If yes, please explain. _____

19. Are you currently employed? If yes, please state your job/profession/position and how long you have been at this position. If no, please explain.

_____

20. Do you enjoy your work? Do you consider your work place and/or job stressful?

_____

21. Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief.

_____

22. What do you consider to be some of your personal strengths?

_____

_____

_____

23. What do you consider to be some of your weaknesses?

_____

_____

_____

24. What would you like to accomplish during your time with Sandra?

_____

_____

_____

_____

Client Name: (*Print*) _____ Date: _____

Client Signature: _____ Date: _____

Read and Reviewed by: _____ Date: _____

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Office Policy and Procedures

Expectations:
Having clear goals, or expectations are useful in a counseling journey as long as individuals, couples or families understand they are the essential variable in us reaching those outcomes. Counseling can open up new levels of awareness that may cause discomfort throughout the counseling journey. Having open and honest communication is an essential expectation of the therapy process.

Length of therapy:
All sessions are 50 minutes in length. An additional 10 minutes is used for payment, scheduling future appointment and/or other business dealings.

Payment for Services:
The fee for services is $120 per 50-minute session. Payments are to be made immediately following each session. Cash, checks and Venmo are accepted.

Cancellation of Appointments:
On occasion, a situation may arise which prevents you from keeping a scheduled appointment. Please notify me of cancellations at least 24 hours in advance of your appointment. Except in emergency situations, you will be charged your fee for no shows or late cancellations of scheduled appointments.

Confidentiality:
I have been offered the "*Notice of Privacy Policies*." I understand my rights as they have been explained to me in this document. If I have any further questions regarding my Personal Health Information (PHI) or confidentiality within the counseling process I will seek clarification. I have also been given a "*Consent to Release Information*" which gives *Breathing Space Today, LLC*. the right to release (PHI) if completed.

I understand that my patient records are property of *Breathing Space Today, LLC.* and shall be treated as confidential; that *Breathing Space Today, LLC.* will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the laws of the state where I am receiving treatment. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using "*Authorization for Use and Disclosure of Protected Health Information*" form or another acceptable form, with the exception of information I have agreed to release per this acknowledgment.

Consent for Treatment:
I have consented to treatment provided by *Breathing Space Today, LLC.* I authorize the services deemed necessary or recommended to address my needs. I acknowledge that *Breathing Space Today, LLC.* is not a 24/7 treatment care facility and that I am responsible for seeking care at my nearest emergency center or through another provider when *Breathing Space Today, LLC*. is not available.

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the counseling process at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

Clients Signature **Date**

Clients Signature (partner or parent if applicable) **Date**

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Consents to Release Information

I hereby consent for *Breathing Space Today, LLC*. to contact the following parties as noted below regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at *Breathing Space Today, LLC*. for 90 days following my last visit unless expressly revoked by me in writing.

Examples of person(s) you may want to consent to release information to; EAP/Insurance company (necessary for billing purposes), PRN, IPN, LAP, family and/or friends who may contact me in regard to your treatment IF you want me to communicate with any of these above mentioned or other treating medical professionals, please include their names and phone numbers below along with reason for release

Name:_____ Phone #: _____

Reason for release of information:

_____

Name:_____ Phone #: _____

Reason for release of information:

_____

Name:_____ Phone #: _____

Reason for release of information:

_____

_____ _____

Client Signature **Date**

NOTICE OF PRIVACY PRACTICES

Overview

This notice provides you with information about how your mental health records at my office may be used, the rights you have as a patient, and my legal duties as a provider of treatment. I am required to provide you with this notice under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which took effect on April 14, 2003. This law is designed to protect the confidentiality of your treatment and records created as part of your treatment. Please review it carefully. Let me know if you have any questions or would like additional information.

How We May Use and Disclose Health Information about You, With Authorization

- Treatment- This is when I provide or coordinate your healthcare. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist,
- Payment-Your PHI may be disclosed in order to collect payment for services provided or to determine insurance eligibility or coverage.
- Operations-Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations include quality assessment and improvement activities, business-related matters such as audits and administrative services, care coordination, accreditation, certification, licensing or credentialing activities.

How We May Use and Disclose Health Information about You, *WITHOUT* Consent or Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances, as required by state and Federal law:

- Prevention of serious harm, or death, to yourself or others.
- Child Abuse: If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to the Florida Department of Social Services
- Abuse of Elderly or Incapacitated Adults: If I have reason to suspect that an incapacitated adult (e.g. someone who is not able to advocate for himself or herself) is being abused, neglected or exploited, I am required by law to make a report and provide relevant information to the Florida Department of Social Services.
- If required to do so by federal, state or local law.
- In response to a court order, subpoena, warrant, summons or similar process.
- Supervision: I may discuss your treatment with colleagues to improve the quality of your care. However, your name or other identifying information that could identify you will not be used.
- Disclosure may be made if a therapist must arrange for legal consultation if a patient takes legal action against a therapist.

Other Uses and Disclosures of Health Information

Except where otherwise required or authorized by law, I will not use or disclose your health information for any purpose without your written authorization. If you authorize me to use or disclose health information about you, you may revoke your authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose your health information for the reasons covered by your written authorization, but I cannot take back any uses or disclosures I have already made with your permission.

Your Rights Regarding Your Health Information:

- Right to Request Restrictions – you have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, I can send your communications to an address other than your home if you request.
- Right to Inspect Records – You may inspect and copy your health information, with certain exceptions.
- Right to Amend- If you believe that the health information I have about you is incorrect or incomplete, you may ask us to amend the information.
- Right to a paper copy- You have the right to receive a paper copy of this notice.

If you have any questions or wish to exercise any of these rights, please let me know with a written request at any time.

Private Safeguards
This office has developed appropriate administrative, technical, and physical safeguards to protect the privacy of your Protected Health Information. These including placing locks on file cabinets, shredding documents with identifying information, using passwords on computers, as well as other safeguards.

Uses and Disclosures Involving Personal Representatives
Where an incapacitated patient has a guardian or legal representative with authority to make health care decisions for the patient, I must treat the guardian or legal representative as the patient with respect to PHI. If the patient is a minor child, the therapist must treat the parent (or legal guardian) as the patient with respect to PHI. However, if the therapist has reasonable belief that a parent, guardian, or legal representative has subjected or may subject the patient to abuse or neglect or otherwise endanger the patient, and believes that it is not in the patient's best interest to release such information, the therapist may elect not to treat the parent or guardian as the patient and hence not disclose confidential information. A parent or guardian may allow a confidentiality agreement between the minor patient and the therapist.

Complaints
If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Sandra Chmielewski at 952-412-4985. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Sandra Chmielewski at 25344 Wesley Chapel Boulevard, Lutz, FL 33449.
You may also file a complaint with the Department of Health or Secretary of the U.S. Department of Health and Human Services.

Effective Date, Restrictions and Changes to this Privacy Policy
This notice will go into effect on March 1, 2023. I have the right to change this notice. If I do so, the new notice will apply to the health information we may already have about you and to the health information that we receive in the future. I am required to abide by the most current notice that is in effect. You are entitled to receive a copy of the most current notice.