ELIZABETH GOROVITZ
Individual and Relationship Counseling

Welcome!

I am honored to have the opportunity to work with you. This packet contains information and forms that must be completed prior to our first meeting. Please review and sign the Disclosure Statement and Notice of HIPPA Legislation. In addition, depending on the nature of your therapy, please complete either the Individual Client Intake Form or the Couples Counseling Intake Forms (*to be completed by each partner*).

Please review and complete the following documents:

- Disclosure Statement—to be reviewed and signed (pages 2-3)
- Individual Client Intake Form (pages 4-6)
- Couples Counseling Intake Forms (pages 7-10)
- Notice of HIPPA Legislation—to be reviewed and signed (pages 11-13)

Thank you for choosing to seek counseling with me. I look forward to working with you.

Sincerely,

Elizabeth Gorovitz

Elizabeth Gorovitz, MS, LMFT

Welcome to my practice. I am committed to providing client-centered, time-effective treatment to individuals, couples, and families regardless of race, sex, age, or religious affiliation. The following information will help you understand many of the details about your therapy.

COMMUNICATION

You may call 407-701-6441 or email egorovitz@gmail.com with any questions you may have about your treatment. I am often not immediately available by telephone. I monitor my confidential voicemail daily, and I will make every effort to return your call within 24 hours, except on weekends and holidays. If you have a therapy emergency, please call Lifeline Crisis Line at 407-425-2624 or 911.

I recommend that email only be used for scheduling and not for personal counseling or conversations. Email has limitations, and confidentiality cannot be guaranteed.

CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Professional records will be stored in a locked cabinet or in secured electronic devices. I will keep all session notes, contact information, and any other related documents in a locked secured location, consistent with the laws and regulations for the storage of private health information. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, I am required to warn the intended victim and report this information to legal authorities. If a client discloses or implies a plan for suicide, I am required to notify legal authorities and make reasonable attempts to notify the client's family.

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, I am required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
I am required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of minor clients have the right to access the clients' records. Typically, I encourage parents to waive access to a minor's records to preserve the integrity of the counseling relationship. I will provide parents with general information about the minor's progress in therapy.

Insurance
I may have to confirm information about services if your insurance company requests it to determine your reimbursement.

Legal
If a client is involved in court or legal proceedings, I may be subpoenaed by a court to release records or provide information about treatment. Please note: I will not voluntarily participate in any litigation or custody dispute. I will not communicate with a client's attorney and will not write or sign letters, affidavits, or reports to be used in a client's legal matters. I will not provide testimony or client records unless court-ordered.

CONFIDENTIALITY IN COUPLE'S COUNSELING

I believe it is in a couple's best interest if partners don't keep secrets from each other over time. Secrets can undermine the process of improving and strengthening a couple's relationship and prevent the couple from achieving their therapy goals. If one member of the couple reveals information about the relationship to me and indicates that this information is to be kept confidential from his or her partner, I will decide whether keeping this information secret would be in the best interest of the couple's counseling goals.

SESSIONS

Individual, couples, and family sessions are typically scheduled for 50 minutes. Intake sessions, as well as some couples and family sessions, are sometimes longer, approximately 80 minutes. Duration and frequency of therapy is usually determined by what you and I deem appropriate. You will likely decide when therapy is over. My hope is that you will end therapy when you have achieved your goals and obtained what you wanted from the experience.

TREATMENT FEES AND PAYMENT POLICY

I see clients on a fee-for-service basis only. The regular fee schedule is as follows: 1) $125 for a 50-minute individual, couple, or family session; 2) $65 for a 25-minute individual, couple, or family session; 3) $185 for an 80-minute individual, couple, or family session. Telephone calls lasting less than 15 minutes will not be charged.

The client is responsible for payment in full at the time of each session via personal check, cashier's check, cash, or credit card. Any other arrangements must be made in advance. A $25 fee will be charged on all checks that are returned for non-sufficient funds.

INSURANCE

Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement to your insurance company. I am not contracted ("in network, preferred provider") with any insurer, but I will provide you with a receipt that you may submit for reimbursement if you choose. Please note that I do not complete any insurance paperwork.

CANCELLATIONS

I understand that it may, at times, be necessary to cancel an appointment. I require that any changes or cancellations be made at least 24 hours in advance. A full session fee is charged for missed, cancelled, or changed appointments with less than a 24-hour notice, unless it is because of illness or an emergency.

ADDITIONAL CONSIDERATIONS

Counseling can have risks as well as benefits. Discussing unpleasant areas of your life and trying to cope with difficult thoughts and emotions can be very upsetting. Changing your behavior and altering your beliefs can sometimes be disruptive to the relationships in your life. It is important to consider these possibilities before entering into therapy and decide whether or not you believe the potential rewards outweigh any possible risks. Research indicates that most people benefit from therapy, but there are no guarantees of outcome, or what you will experience. Therapy is a significant investment of time, money, and energy; it is most effective when there is active effort on your part, both in sessions and at home.

FINANCIAL AGREEMENT AND CONSENT FOR TREATMENT

I have been informed of, read, and agree to the preceding information. I consent to treatment of the person named below and agree to pay all fees as stated above.

_____

Client Name (please print)

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Elizabeth Gorovitz, MS, LMFT Date

INDIVIDUAL CLIENT INTAKE FORM

Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor): _____
(Last) (First) (Middle Initial)

Birth date: _____ /_____ /_____ Age: _____ Number of Children: _____

Relationship status: ( ) Never Married ( ) Partnered ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Primary phone: ( ) _____ May I leave a message? ( ) No ( ) Yes

Secondary phone: ( ) _____ May I leave a message? ( ) No ( ) Yes

Email: _____ May I email you? ( ) No ( ) Yes
**Please be aware that email might not be confidential.*

Referred by: _____

Emergency contact:_____
(Name) (Phone number)

Relationship:_____

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ( ) No ( ) Yes

Have you had previous psychotherapy? ( ) No ( ) Yes *If yes, previous therapist's name:* _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) No ( ) Yes *If yes, please list:* _____

_____

If no, have you been previously prescribed psychiatric medication? ( ) No ( ) Yes *If yes, please list:* _____

_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? ( ) Poor ( ) Unsatisfactory ( ) Satisfactory ( ) Good ( ) Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

3. Are you having any problems with your sleep habits? ( ) No ( ) Yes *If yes, check where applicable:*
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep ( ) Disturbing dreams
( ) Other _____

4. How many times per week do you exercise? _____ Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? ( ) No ( ) Yes
If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Binging ( ) Restricting
Have you experienced significant weight change in the last 2 months? ( ) No ( ) Yes

6. Do you regularly use alcohol? ( ) No ( ) Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use? ( ) Daily ( ) Weekly ( ) Monthly ( ) Rarely ( ) Never

8. Have you had suicidal thoughts recently? ( ) Frequently ( ) Sometimes ( ) Rarely ( ) Never
Have you had them in the past? ( ) Frequently ( ) Sometimes ( ) Rarely ( ) Never

9. Are you currently in a romantic relationship?( ) No ( ) Yes *If yes, how long have you been in this relationship?* _____
On a scale of 1-10 (10 being best), how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors? _____

_____

Please indicate if you have experienced any of the following:

_____ Extreme depressed mood
_____ Wild mood swings
_____ Rapid speech
_____ Extreme anxiety
_____Panic attacks
_____ Phobias
_____ Hallucinations
_____ Unexplained losses of time
_____ Homicidal thoughts
_____ Unexplained memory lapses
_____ Alcohol/substance abuse
_____ Frequent body complaints
_____ Eating disorder
_____ Body image problems
_____ Repetitive thoughts (e.g., obsessions)
_____ Repetitive behaviors (e.g., frequent checking, hand-washing)
_____ Suicide attempt

Are you experiencing any of the above currently? ( ) No ( ) Yes *If yes, please list and indicate for how long:* _____

_____

_____

OCCUPATIONAL INFORMATION:

Are you currently employed? ( ) No ( ) Yes

If yes, please list current employer/position: _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ( ) No ( ) Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ( ) No ( ) Yes

FAMILY MENTAL HEALTH HISTORY:

Please indicate if anyone in your family (either immediate family members or relatives) has experienced difficulties with any of the following. *For those items you check, please indicate family member's relationship to you:*

Difficulty	**Family member:**
_____ Depression	_____
_____ Bipolar Disorder	_____
_____ Anxiety disorders	_____
_____ Panic attacks	_____
_____ Schizophrenia	_____
_____ Alcohol/substance abuse	_____
_____ Eating disorders	_____
_____ Learning disabilities	_____
_____ Trauma history	_____
_____ Suicide attempts	_____

OTHER INFORMATION:

What do you consider to be your strengths? _____

_____

What do you like most about yourself? _____

_____

What effective coping strategies have you learned? _____

_____

What are your goals for therapy? _____

_____

COUPLES COUNSELING INTAKE FORM - Partner 1

Last Name:_____ First: _____

Address:_____

Birth date:_____ Age:_____ Occupation:_____

Primary phone: ( ) _____ May I leave a message? ( ) No ( ) Yes

Secondary phone: ( ) _____ May I leave a message? ( ) No ( ) Yes

Email: _____ May I email you? ( ) No ( ) Yes

**Please be aware that email might not be confidential.*

Highest level of education:_____

Relationship status (check all that apply):

( ) Married ( ) Separated ( ) Divorced ( ) Engaged ( ) Dating ( ) Living together ( ) Living apart

Length of time in current relationship:_____

On a scale of 1-10 (10 being best), how would you rate your relationship?_____

Please list children (names and ages):_____

_____

Who lives with you?_____

Please check any of the following reasons that led to your request for counseling:

( ) Depression or anxiety	( ) Substance abuse	( ) Communication problems	( ) Improve sex life
( ) Child/parent conflict	( ) Divorce counseling	( ) Financial issues	( ) Work/school problems
( ) Grief	( ) Family counseling	( ) Individual counseling	( ) Pre-marital counseling
( ) Relationship enrichment	( ) Thoughts of self-harm	( ) Sexual identity concerns	

Have you ever been abused (physical/emotional/sexual)? ( ) No ( ) Yes *If yes, please describe (by whom and for how long):*

_____

_____

What is your primary reason for seeking counseling at this time? _____

_____

_____

How long have these concerns been causing you distress?_____

_____

What have you already done to deal with the difficulties? _____

_____

What would you like to accomplish in counseling? _____

_____

What are your greatest strengths as a couple? _____

_____

Have you ever received counseling before? ( ) No ( ) Yes *If yes, when, with whom, and outcome:*

_____

_____

How would you rate your current physical health? ( ) Poor ( ) Unsatisfactory ( ) Satisfactory ( ) Good ( ) Very good

Please list any current health concerns:_____

_____

Are you currently taking any prescription medication? ( ) No ( ) Yes *If yes, please list:*_____

_____

_____

Have you ever been prescribed psychiatric medication? ( ) No ( ) Yes *If yes, please include drug name, reason for taking, and dates:*_____

_____

Do you have any questions that you'd like me to address at our first meeting?_____

_____

_____

Referred by (if any):_____

EMERGENCY CONTACT

Name:_____ Phone number:_____

Relationship:_____

Client Signature_____ Date_____

COUPLES COUNSELING INTAKE FORM - Partner 2

Last Name:_____ First: _____

Address:_____

Birth date:_____ Age:_____ Occupation:_____

Primary phone: ( ) _____ May I leave a message? ( ) No ( ) Yes

Secondary phone: ( ) _____ May I leave a message? ( ) No ( ) Yes

Email: _____ May I email you? ( ) No ( ) Yes

**Please be aware that email might not be confidential.*

Highest level of education:_____

Relationship status (check all that apply):

( ) Married ( ) Separated ( ) Divorced ( ) Engaged ( ) Dating ( ) Living together ( ) Living apart

Length of time in current relationship:_____

On a scale of 1-10 (10 being best), how would you rate your relationship?_____

Please list children (names and ages):_____

_____

Who lives with you?_____

Please check any of the following reasons that led to your request for counseling:

( ) Depression or anxiety	( ) Substance abuse	( ) Communication problems	( ) Improve sex life
( ) Child/parent conflict	( ) Divorce counseling	( ) Financial issues	( ) Work/school problems
( ) Grief	( ) Family counseling	( ) Individual counseling	( ) Pre-marital counseling
( ) Relationship enrichment	( ) Thoughts of self-harm	( ) Sexual identity concerns	

Have you ever been abused (physical/emotional/sexual)? ( ) No ( ) Yes *If yes, please describe (by whom and for how long):*

_____

_____

What is your primary reason for seeking counseling at this time? _____

_____

_____

How long have these concerns been causing you distress?_____

_____

What have you already done to deal with the difficulties? _____

_____

What would you like to accomplish in counseling? _____

_____

What are your greatest strengths as a couple? _____

_____

Have you ever received counseling before? ( ) No ( ) Yes *If yes, when, with whom, and outcome:*

_____

_____

How would you rate your current physical health? ( ) Poor ( ) Unsatisfactory ( ) Satisfactory ( ) Good ( ) Very good

Please list any current health concerns:_____

_____

Are you currently taking any prescription medication? ( ) No ( ) Yes *If yes, please list:*_____

_____

_____

Have you ever been prescribed psychiatric medication? ( ) No ( ) Yes *If yes, please include drug name, reason for taking, and dates:*_____

_____

Do you have any questions that you'd like me to address at our first meeting?_____

_____

_____

Referred by (if any):_____

EMERGENCY CONTACT

Name:_____ Phone number:_____

Relationship:_____

Client Signature_____ Date_____

Elizabeth Gorovitz, MS, LMFT

Notice of HIPPA Legislation

To comply with federal HIPPA regulations concerning safety of Health Care Information, I provide every client with the opportunity to read my Notice of Privacy Practices (see below). Your signature on this form acknowledges that you had the opportunity to do so and ask questions.

Acknowledgement of Receipt of Privacy Notice (please bring to first session)

Client name: _____ Date: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Elizabeth Gorovitz's Notice of Privacy Practices. I understand that if I have any questions regarding this Notice of Privacy Practices or of my privacy rights, I can contact Elizabeth Gorovitz.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date

Elizabeth Gorovitz, MS, LMFT
1850 Lee Road, Suite 103 , Winter Park, FL 32789
407•701•6441

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information"(PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. If you suspect a violation you may file a report to the appropriate authorities in accordance with Federal regulations.

Your Rights regarding Your PHI

You have the following rights regarding PHI (Protected health information) I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

Right to a Copy of this Notice. You have the right to a paper copy of this notice.

Right of Complaint. You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

Treatment. Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.

Payment. I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Healthcare Operations. I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist in the delivery of health care, provided I have a written contract requiring the recipient(s) to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health-related products or services that may be of interest to you.

Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law, such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third-party payers).

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report.

Coroners, Medical Examiners and Funeral Directors. I may disclose PHI of a deceased patient to a coroner or medical examiner for the purpose of identifying the deceased patient, determining the cause of death, or other duties as authorized by law. I may also disclose PHI to a funeral director as may be necessary to carry out its duties with respect to the deceased patient.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety to the public or another person.

Criminal Activity on My Business Premises/Against Me and My Staff. I may disclose your PHI to law enforcement officials if you have committed a crime on my premises or against me or my staff.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order.

Uses and Disclosures of PHI with Your Written Authorization
Other uses and disclosures of your PHI will be made only with your written authorization.
You may revoke this authorization in writing at any time; unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

This Notice
This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the - terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that
I maintain at that time. I will make available a revised Notice of Privacy Practices by providing one to you at your next appointment or mailing you a copy at your request.

Contact Information
I am my own Privacy Officer. So, if you have any questions about this Notice of Privacy Practices, please contact me. My contact information is on the letterhead at the beginning of this notice.

Complaints
If you believe I have violated your privacy rights, you may file a complaint in, writing to me, as my own Privacy Officer, specified on the first page of this Notice. **I will not retaliate against you for filing a complaint.** You may file a complaint with the U.S. Secretary of Health and Human Services.