Heather R. Fisse-Repole, RMHCI, LMT, RYT, MS
Registered Mental Health Counseling Intern
Licensed Massage Therapist
Registered Yoga Teacher

Professional Disclosure Statement

COUNSELING PHILOSOPHY AND APPROACH

It is my belief that all individuals are conceived with an innate motivation towards balance and happiness and that we possess the ability to achieve this state of wellness independently and within our social systems. Throughout our lives, from conception to present day, we are faced with many events that may pose as obstacles to our maintaining this state of wellness and as a result we may develop patterns of behaviors, thoughts, emotional processing and interaction styles that present as unhealthy and distressful. The purpose of counseling is to provide a safe environment and personal connection to be able to explore and identify the development of these dysfunctional processes. Through obtaining understanding about the origin and initial purpose of these maladaptive processes we become more adept at being able to challenge them and replace them with healthy, adaptive behaviors. My role as a counselor is to assist you through this process while respecting and promoting your natural capacity to make informed choices as well as to responsibly act in ways that will better the life of oneself and one's surrounding system (family, friends, work, community, etc.). I will work to facilitate growth, healing, insight, and the exploration of choices reflective of the responsibility and wisdom you possess with respect to your situations. I hold a strong belief that the mental, emotional, relational, physical, and spiritual components of each person work together to make up how we perceive ourselves and our surrounding world. I will work to support the integration of these aspects of your life to the extent that you are willing and feel it is appropriate.

I do not value the role of pathology in striving towards health and wellness and therefore do not rely on formal diagnosing or labeling. I perceive this practice to be counterproductive as it often discourages empowerment of you, the client. I am more concerned with identifying factors that contribute to the development of the behavior, thoughts, emotions and/or relationships that you are seeking relief for; these may include areas pertaining to childhood, trauma, physiological dysfunction, lack of fulfillment and purpose, to name a few.

Your participation in the entire therapeutic process is vital for therapy to be most effective as you and only you possess the power to change your life. We will work collaboratively to form treatment goals. Given the intimate nature of counseling and the willingness to explore areas in life that may be uncomfortable or painful it is important to acknowledge that along with the benefits there can be short-term risks, such as: uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. I request that you make me aware of any of these feelings throughout the counseling process so that we can work to fully process through them and receive the greatest benefit of the work. Therapy often leads to enhanced relationships, solutions to specific problems, and significant reductions in feelings of distress.

EDUCATION, TRAINING, AND EXPERIENCE

I hold a Master's in Clinical Mental Health Counseling from a CACREP accredited program at the University of North Florida. I am currently a Florida State Registered Mental Health Counseling Intern (IMH10164). As a pre-licensed professional I receive regular supervision by Dr. David Whittinghill (MH4697) who is a licensed mental health professional and is qualified as a Certified Supervisor with the state of Florida. I am currently working towards becoming certified in Psychodrama therapy and have obtained 95+ hours of training. Further, I have attended multiple trainings on Interpersonal Neurobiology as well as functional medicine approaches to psychological distress and the connection of brain and body dysfunction.

In addition, I graduated from Southeastern School of Neuromuscular Massage in 2008 and have been practicing as a licensed massage therapist (lic. # MA53350) since that time. In this role I have gained tremendous insight on wellness as well as an appreciation and understanding that a holistic view of my clients promotes the greatest benefits to them.

Currently, I work in a multidisciplinary practice that promotes health and wellness through the avenues of mental health counseling and life coaching, nutrition, chiropractic, massage therapy, physical therapy, yoga, and various mind/body therapies. In my role as a counselor I will provide counseling services to all ages of individuals, couples and families with a variety of concerns. I have experience working in both an Inpatient facility as well as at a University counseling

clinic. My experience includes working with individuals struggling with addictive behaviors, chronic mental health concerns, and overall lifestyle adjustments in both a group and individual setting. Frequently addressed issues may include those of mood and anxiety related concerns, generalized stress, interpersonal/relationship issues, past trauma, existential concerns (meaning, purpose, suffering, loss, and death), family of origin dysfunction, enhancing self-esteem, life adjustments and major decisions, lifestyle concerns as well as numerous other concerns.

DUAL RELATIONSHIPS/ "OUT OF OFFICE CONTACT"
In order to promote a healthy therapeutic relationship certain boundaries and policies have been established to ensure the safety, respect, and independence necessary for growth, nurture and understanding. Once we have entered into the counseling relationship together this will become our priority relationship and all other interactions will become secondary in nature and avoided if they do not directly contribute to the benefits of our therapeutic relationship.
Although we may have already established a professional relationship through my alternative role as a massage therapist at JHWC it is my strong belief that continuing such relationship would compromise the egalitarian qualities necessary in the counseling relationship and will not be supported once counseling has initiated. Referral to other massage therapists in the center and/or community will be provided in efforts to meet any continued care needs.
Conversely, if the onset of our interaction takes place within the counseling arena then all future dual relationships will be avoided even after we no longer engage in counseling (ie: no transitioning from being a counseling client to a massage client).
Additionally, it is office policy to limit the duration of outside contact that is deemed unrelated to counseling such as "running into each other" in public and/or "friending" on facebook and similar social network sites to name a couple prominent examples.
At some point, I or another member of the Center's staff may engage in a consumer relationship with you if you are a provider of services and/or products in the community. We are happy to support practice member's businesses but will not be able to accept any special treatment or discounts. Any non-currency exchange (barter) will occur at the standard and established monetary value.

COUPLES AND FAMILIES
Working from a holistic framework often views individual concerns as being part of a greater dysfunction in a social system. Couple's and Family Counseling will include members of these systems in order to promote growth and understanding of the interdependent patterns that exist. This type of counseling does not view one individual as the cause of a system's dysfunction and will work to create balance and wellness in these connections while benefitting the individuals involved.
In order to avoid conflict of interest, it is my policy that I will not be able to merge individual therapy into couple's and/or family therapy once I have seen an individual more than 4 sessions. If the need for couple's and/or family counseling should emerge I will provide you with referrals for these services in the community. NOTE: This does not exclude family members or partners from participating in an individual session if it is mutually agreed as a benefit by both counselor and client.

GROUPS
Group therapy can often enhance the growth that is being experienced during individual counseling and can be used as an adjunct to individual counseling or independent of it (if appropriate). I truly believe that the benefits of group therapy are countless!
Groups are ongoing and address a variety of concerns that may or may not be appropriate for you. Some group will be psycho-educational in nature and may have duration of only a single session (examples include: progressive muscle relaxation, mind/body connection, time management, nutrition and exercise regimens, etc). These groups are considered "open groups" as they do not require a screening or a long-term commitment. While other groups will be more process oriented and will often take place over the course of 8-12 weeks (examples include: disordered eating, past trauma, couples, anxiety, interpersonal development, etc). These groups are considered "closed groups" as they will require a screening for appropriateness as well as a commitment to attend all sessions so that safety and stability can be felt amongst group members.

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FEES FOR SERVICES

Individual Counseling:
First session: $125/ 90 minute session
Follow-up sessions: $80/ 50-60 minute session

Couples Counseling:
First session: $150.00/ 90 minutes
Follow-up sessions: $100.00/60-70 minutes

Group Counseling:
Open Group: $20.00-$50.00 per group (price varies based on specific group)
Closed Group: $300.00/ Commitment to 8-12 consecutive group sessions (This is a non-refundable fee once the group has completed the first three sessions). An additional $50.00 screening fee will apply if you are not already an established client.

Psychosocial w/ Written Report:
$200.00

Miscellaneous professional services including but not limited to: letter writing, telephone conversations greater than 10 minutes, preparations for records, and attendance at meetings with professional you have authorized to give a few examples (excludes court related legal documents *see specific legal fees)
These services will be provided at the hourly rate and prorated if they do not require the full hour to complete.

Legal Fees:
If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $150 per hour for preparation and attendance at any legal proceeding.

A fee schedule for all other services provided by Jacksonville Health & Wellness Center is available from support staff as well as online at www.drrepole.com.

******Student discounts are available for the college population******

******Financial Hardships may warrant participation in a discounted sliding fee scale and are based on individual's income******

BILLING AND PAYMENTS

Payment will be collected at the time of service and accepted in the form of cash, check or credit card (excluding American Express). At this time I do not accept Insurance for services rendered but will be happy to provide you with the necessary documentation in order for you to file for reimbursement. Payment arrangements will be reviewed on a case-by-case basis and require the recording of credit card information to secure a financial payment plan.

CANCELLATION POLICY

Your participation and attendance of each session is very important in order to obtain the greatest benefits of counseling. In addition, I will spend time preparing for your visit to ensure that we have the maximum opportunity for growth in every session so I ask in return that if you have a challenge that prevents you from attending an appointment please call the office to reschedule the appointment with a minimum of 24 hours notice in order to avoid a $25.00 cancellation fee.
If you have missed two consecutive appointments and have not had contact with this office all appointments that may have been scheduled in advance will be removed from the calendar to avoid additional cancellation fees.
Please know that I understand that there may be incidences that arise that make your attendance unavoidable and these will be reviewed on a case-by-case basis.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my general policy to provide your parents/guardians only with general information about our work together, unless I feel there is a high risk that you are being harmed, will seriously harm yourself or will harm

someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY LIMITIONS
By law and professional ethics, your sessions are confidential with the exception of the following possibilities:

- If you are a victim or perpetrator of child abuse
- If you are a victim or perpetrator of elder or dependent adult abuse
- If you threaten harm to yourself~ someone else, or the property of others
- If your counselor is ordered by court to testify or release records
- If you provide written consent that your information may be shared with another party.

Confidentiality during couples and family therapy is different. The therapist will not hold family secrets from other family members that are detrimental to the health and/or welfare of the family. Instead, the therapist will assist the family member that has a secret to share it with their family in a safe manner.
Confidentiality during group therapy cannot be guaranteed. Other group members are not therapists and are not bound by the same ethical codes that counselors are. While we request that everything shared in a group be kept confidential, there is no guarantee that group members will comply.
It is common practice and in accordance with our code of ethics to consult with colleagues regarding matters that we belief they may contribute valuable resources or alternative points of view. During consultation, I make every effort to avoid revealing the identity of my client and ensure that the consultant is also legally bound to keep the information confidential.
In addition, in my role as a Registered Mental Health Counseling Intern I am required by Florida licensing law to have immediate access and consultation with my registered supervisor (Dr. David Whittinghill, MH4697). The purpose of my required consultation with the above named registered supervisor guarantees you a greater quality of care and is believed to pose no detriment and only benefit.
Lastly, information may be shared with other clinicians here at JHWC as we utilize a team approach in supporting the individual's whole body. The sharing of information will only occur if it presents as being beneficial for your development and growth. All employees of JHWC are bound by the governing HIPAA laws (*see Notice of Privacy Practices) and will function in compliance with the above outlined confidentiality agreement.

CONTACT/EMERGENCIES
Due to the nature of the counseling session, I am not always immediately available for contact by phone. Please feel free to leave a message and every effort will be made to return your call within 24 hours during the week and 48 hours over the weekend. If for any reason you feel that you need to speak to someone immediately, I have provided a list of emergency resources below.
Emergency Service – 911
Suicide or Crisis Hotline (In Duval) – 211, (904) 632-0600, or 1-800-346-6185
Hubbard House – (904) 354-3114
Baptist Behavioral health Hospital Health – (904) 376-3822
JASMYN – (904) 389-3857

TERMINATION
You are free to take a break from, end, or request a referral for treatment at any time. It is encouraged that we talk about the reason for your decision so that sufficient closure can be given to our therapeutic relationship as well as any referrals can be made for treatment options that will best meet your desired needs.

PROFESSIONAL RECORDS

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The laws and standards of my profession require that I keep treatment records for a minimum of 7 years. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests and making copies.

COMPLAINTS/DISPUTES PROCEDURES

If you have any questions or concerns about services provided to you by any licensed or registered Counselor and have been unable to resolve issues with said individual to a level of satisfaction, they should be directed to the:

- *Board of Clinical Social Work, Marriage & Family Therapy, and Mental Health Counseling @ 4052 Bald Cypress Way, BIN C-o8, Tallahassee, FL 32399, 850.245.4474 or 850.921.5389(fax)*
- *Florida Department of Mental Health Professions at (888) 419-3456 or (850) 414-1976*

  You may obtain a copy of the Code of Ethics from the American Counseling Association at www.counseling.org or 1(800) 422-2648.

PATIENT RECORD OF DISCLOSURE

I wish to be contacted in the following manner (for emergency, non emergency, disclosure of testing/diagnostic results, scheduling of appointments, etc.) (check all that apply).

☐ Home Telephone --------------- ☐I approve leaving a voicemail
☐ Cell Phone ------------------☐I approve leaving a voicemail
☐ Work Telephone --------------☐I approve leaving a voicemail
☐ Written communication ------------ ☐Home Address and/or ☐ Email

ACKNOWLEDGEMENT/INFORMED CONSENT

My signature below shows that I understand and agree with all of these statements and that I have received information about the therapy that I am considering.

- Your signature indicates that you not only understand and agree to the above terms of counseling but that you also have a desire and hope for growth and wellbeing as well as recognize the potential limitations of counseling. In addition, your signature represents an understanding that this counselor has made no promise or guarantee to the results of any treatment or procedure provided.
- Your signature also supports that it is your responsibility to inform this counselor if any conflicts should emerge in the future with these office policies or if there is a change in your ability to benefit from counseling.

I have received, read and understood the following documents:
a.) Notice of Privacy Practices______(initial)
b.) Patient Bill of Rights ______(initial)

STOP:: Please discuss with counselor any questions, concerns, or objections that you may have with these policies before signing.

I/We have read this disclosure statement, have had time to address and clarify any questions and understand the contents:

Client Name:____ Date:____________________________

Signature:____

Parent/Guardian Name and Relationship:____

P/G Signature:_______________________________________Date:_____________________________

Counselor Signature:____________________________________Date:________________________________

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PATIENT INFORMATION

Name_________________________________ Date ______ Gender________ Age ______ Ht._____ Wt.______
Birthdate____________________ Social Security # _______________________
[ ] Married [ ] Widowed [ ] Single [ ] Minor [ ] Separated [ ] Divorced [ ] Partnered for ______ years
Address____
City____________ State_________________ Zip ____________
Occupation______________________________ Patient Employer/School___________________________________

SPOUSE/PARTNER/FAMILY

Name____ Birthdate________________
Social Security #__________________________ Occupation____
Please list children and their ages:____
____

PHONE NUMBERS/CONTACT INFORMATION

Home Phone (____) _________________________ Cell Phone (_____) _____________________
Work Phone (_____) ____
Best time to call and reach you__________________________ E-Mail address_______________________________
In case of emergency contact:
Name______________________________Relationship___________________ Phone__________________________

PRIMARY MEDICAL DOCTOR

Doctor Name_____________________________________ Speciality_______________________________________
Phone Number______________________________ Address____

REFFERAL

How did you hear about our office or who were you referred by:____

APPROVED OFFICE COMMUNICATION

Occasionally it will be necessary for our office to contact you regarding appointments or other matters about counseling. Please ONLY mark "Yes" and provide phone number/email for the methods of contact that you are comfortable with receiving calls, messages, and information from our office on. We will always try to be discrete in any messages we leave, but we cannot guarantee confidentiality once the message is left.

Home: May we contact you at your home telephone number? □Yes □No # ______________________________
Work: May we contact you at your home telephone number? □Yes □No #______________________________
Cell: May we contact you at your home telephone number? □Yes □No #______________________________
E-Mail: May we contact you via e-mail? □Yes □No Email address______________________________
Home Address: May we contact you via written communication? □Yes □No

By signing I certify that all information provided above is accurate and true.

Client Name: ____ Date: ________________
Client or Guardian Signature: ____

Patient Health Questionnaire (PHQ)

All information is kept confidential in adherence with current HIPAA regulations.

Name: ______________________________________ Age:____________ Date: ________________________

People commonly have some problems in the following categories. Please indicate how you are affected by circling the appropriate number beside the item. ***Please circle only ONE number for EVERY item*.**

Not a Problem	A Slight Problem	A Moderate Problem	A Serious Problem	A Severe Problem
0	1	2	3	4

Item	Rating
1. Feeling sad, depressed or unhappy	0 1 2 3 4
2. Feeling discouraged or hopeless	0 1 2 3 4
3. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0 1 2 3 4
4. Little interest or pleasure from things I usually enjoy	0 1 2 3 4
5. Feeling guilty, worthless, helpless	0 1 2 3 4
6. Crying spells	0 1 2 3 4
7. Restless, irritable or agitated	0 1 2 3 4
8. Feeling tired or having little energy	0 1 2 3 4
9. Trouble falling or staying asleep, or sleeping too much	0 1 2 3 4
10.Poor appetite or overeating	0 1 2 3 4
11.Trouble making decisions	0 1 2 3 4
12.Difficulty with concentration	0 1 2 3 4
13.Less interest in sex	0 1 2 3 4
14.Thoughts that you would be better off dead, or of hurting yourself in some way	0 1 2 3 4

Item	Rating
1. Anxious/nervous/worried	0 1 2 3 4
2. Stressed/overwhelmed	0 1 2 3 4
3. Intense fear, panic/discomfort	0 1 2 3 4
4. Panic or fear with physical symptoms (such as pounding heart, sweating, shaking, nausea, dizzy, fear of losing control, etc.)	0 1 2 3 4
5. Anxiety about being in certain situations (such as in a crowd, traveling, standing in line, etc).	0 1 2 3 4
6. Anxiety or fear related to being in social situations or having to perform (such as public speaking, test taking, etc).	0 1 2 3 4
7. Fear, anxiety, or avoiding specific situations (such as flying, heights, animals, etc).	0 1 2 3 4
8. Worrying about health problems	0 1 2 3 4

Item	Rating
1. Having unwanted thoughts over and over again	0 1 2 3 4
2. Repeating specific acts over and over (such as hand washing, checking, etc.) or mental acts (such as counting, repeating words)	0 1 2 3 4

Item	Rating
1. Euphoria (feeling high)	0 1 2 3 4
2. Sudden changes in mood for no apparent reason	0 1 2 3 4
3. Decreased need for sleep (such as feeling rested after only 3 hours of sleep)	0 1 2 3 4
4. More talkative than usual	0 1 2 3 4
5. Racing thoughts	0 1 2 3 4
6. Acting impulsive (such as buying sprees, drinking more, sexual activity, etc.)	0 1 2 3 4
7. Excessive irritability or agitation	0 1 2 3 4
8. Angry outbursts	0 1 2 3 4
9. Property destruction	0 1 2 3 4

Item	Rating
1. Making careless mistakes at school, work or other activities	0 1 2 3 4
2. Difficulty sustaining attention during tasks	0 1 2 3 4
3. Difficulty following through or finishing things	0 1 2 3 4
4. Difficulty in organizing tasks or activities	0 1 2 3 4
5. Easily distracted	0 1 2 3 4
6. Losing things or forgetful	0 1 2 3 4
7. Hyperactivity (can't sit still)	0 1 2 3 4
8. Poor impulse control	0 1 2 34

Item	Rating
1. Hearing things	0 1 2 3 4
2. Seeing things	0 1 2 3 4
3. Experiencing confusion	0 1 2 3 4
4. Memory lapses/forgetting	0 1 2 3 4
5. Feeling of unreality or being outside of self	0 1 2 3 4
6. "Missing time"	0 1 2 3 4
7. Suspiciousness (questioning other people's motives)	0 1 2 3 4

I have been experiencing these problems for:

☐ < 1 Mo ☐1-6 Mos ☐7-12 Mos ☐> 1 Yr

Check any of the following that have caused concern or difficulties during the last 6 months:

☐Taking care of personal grooming needs ☐Preparing meals for family/self ☐Getting along with spouse/parents/ children
☐Taking care of children/others ☐Meeting financial obligations ☐Enjoying of hobbies ☐Meeting "home" responsibilities
☐Getting along with co-workers & others ☐Enjoyment of work ☐Meeting "work" responsibilities
☐Other ____

Current Life Stressors

☐Relationship issues (arguments, separation, divorce) ☐Health issues (illness or injury)
☐Financial (owe money, loss of job, unemployment) ☐Abuse (physical, mental, emotional, sexual)
☐Legal difficulties (law suit, traffic, criminal charges) ☐Substance abuse (alcohol/drugs/food)

If you checked off *any* of the above problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult at all ☐ Mildly difficult ☐ Very difficult ☐Extremely difficult

Briefly describe why you are seeking help at this time:____

____

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Please √ check and list all past & current medical conditions:
(write in specifics and use back of form if necessary)

☐Digestive Dysfuntion (ex: IBS, Gluten Intolerance, Leaky Gut, Diarhea, Constipation, etc.) -

☐Cancer(ex: type, date, tx.)-

☐Cardiovascular (ex: Heart attack, Angina, High Cholesterol, High Triglycerides, Hypertension, etc.)-

☐Autoimmune (ex:☐Diabetes I, RA, Lupus, MS, Lupus, etc.)-

☐Musculoskeletal (ex: chronic pain, headaches, cramps, etc.)-

☐Men's Health Issues (ex: fertility, enlarged prostate, erectile dysfunction, libido, etc.)-

☐Women's Health Issues (ex: PMS, PCOS, menopause, miscarriage, pregnancy, libido, etc.)-

☐Respiratory (ex: TB, chronic cough, asthma, COPD, etc)-

☐Hormonal (ex: hypo/hyperthyroid, Adrenal fatigue, Hashimotos,etc)-

☐Metabolic (ex: weight gain/loss, sugar dysregulation, Diabetes II, Syndrome X, etc.)-

☐Neurological/brain (ex: seizures, memory loss, cognitive deficits, etc.)-

☐Surgeries/Trauma/Hospitalizations (ex: hysterectomy, orthopedic, head injury, concussion, etc.)-

☐Other:______________________________

☐Family Medical History (member of family/condition/ age living or age deceased)-

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Please list all current medications: (Use the back of this form if necessary)

Medication & Condition Prescribed for	Dose	Frequency	Date Started	Prescribed By & Last exam

Please list all PREVIOUS psychotropic/mood-related medications you have EVER taken.

Medication & Condition Prescribed for	Dose	Frequency	Date Started	Prescribed By

Medication Allergies: No ☐ Yes ☐ (Name and Type of Reaction)

____

____

Please list all previous counseling/psychiatric treatment including any psychiatric hospitalizations.

Dates	Reason	Treating Counselor/Doctor/Facility

☐ Yes ☐ No Has any family member ever had a problem with drugs and/or alcohol? If so, who and what?____

____

☐ Yes ☐ No Has any member of your family ever had any history of depression, anxiety, other mental problems, or suicide? If so, who, what type of treatment, and?____

____

____

☐Yes ☐No 1. Do you have thoughts about suicide now?
☐Yes ☐No 2. Have you ever thought about suicide? If yes, when?______________________________

____

☐Yes ☐No 3. Have you ever attempted suicide?If yes, when?______________________________________

____

☐Yes ☐No 4. Do you have access to guns/weapons? If yes, please list type of weapon & location:____________

____

☐Yes ☐No 5. Are you thinking about hurting someone now?
☐Yes ☐No 6. Have you ever thought about hurting someone else?
☐Yes ☐No 7. Have you ever hurt someone else? If yes, please describe circumstance:____________________

____

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Please answer the following questions:

Do you currently drink alcoholic beverages (beer, wine, liquor, etc.)? ☐Yes ☐No

If you have NEVER consumed alcohol skip to next session otherwise please answer the following questions as they pertain to past or present:

If yes, how many alcoholic drinks do you have in the average: day ______, week _______, month ______, year ______

☐Yes ☐No Have you ever sought help for alcohol or drug use (including AA or NA meetings)?

☐Yes ☐No In the past year, have you ever drunk alcohol or used drugs more than you meant to? Or have you spent more time drinking or using than you intended to?

☐Yes ☐No Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?

☐Yes ☐No Have you felt you wanted or needed to ***cut down*** on your drinking or drug use in the last year?

☐Yes ☐No Has anyone ever objected to your drinking or drug use?

☐Yes ☐No Have you ever found yourself preoccupied with wanting to use alcohol or drugs?

☐Yes ☐No Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?

☐Yes ☐No Has your drinking or drug use ever caused legal problems (DUI's, traffic accidents, violence, etc.)?

Check if you have taken any of the following drugs:

☐Marijuana/Pot ☐Cocaine/crack ☐Inhalants
☐Amphetamines/speed ☐Barbiturates/sedatives/downers ☐Designer drugs, Ecstasy
☐Heroin/opiates ☐Intravenous drug use ☐Tranquilizers (Xanax, Valium, etc.)
☐PCP/Angel Dust ☐Pain medicine ☐LSD/hallucinogens

Have you ever taken prescribed medication inappropriately? ☐Yes ☐No

Sleep Difficulties (Check all that apply):

☐Bedwetting ☐Nightmares ☐Reoccurring dreams ☐Falls asleep when emotional
☐ Difficulty falling asleep ☐Walks in sleep ☐Stops breathing during sleep ☐Snoring
☐Early morning awakening ☐Tired upon waking ☐Difficulty staying awake ☐Work Related ______________________________
☐ Difficulty staying asleep *(choose any that apply)* ☐ Hungry ☐Racing thoughts ☐Bathroom

Usually, the time that I … Go to bed is: __________ A.M./ P.M. **and I wake-up at…** _____________A.M./P.M. .

Dietary Habits/Nutrition: *Please list typical meal and time consumed*

Breakfast:____ Lunch:____

Dinner:____ Snacks/other:____

☐Glasses of Water_______(day/wk) ☐Dairy________(day/wk) ☐Caffeine (cups per day): *Tea*_____ *Coffee*______ *Soda*_______

Please describe any current exercise regimen and/or physical activity as well as frequency:____
____

Work Activity: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor ☐Frequent Travel

Tobacco Use: ☐Yes ☐No (*if yes, please list type, frequency, and Age use began):* ____
____

Please answer the following questions:

☐Yes ☐No Is there any history of violence, verbal or sexual abuse in your family?

☐Yes ☐No Have you ever been physically abused?

☐Yes ☐No Have you ever been sexually abused?

☐Yes ☐No Have you ever experienced or witnessed a traumatic event (accidents, crime, major medical illness)?

.

I certify that all information above is true and accurate.

____ ____________________________
Signature of Client, Parent, or Guardian **Date**

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Client/Patient's Bill of Rights

Client/Patient's Rights
In all mental health services, wherever and however they are delivered, clients have the right to be treated with dignity, consideration and respect at all times. Clients have the right:

a) to expect quality service provided by concerned, trained, professional and competent staff.

b) to expect complete confidentiality within the limits of the law, and to be informed about the legal exceptions to confidentiality; and to expect that no information will be released without the client's knowledge and written consent.

c) to a clear working contract in which business items, such as time of sessions, payment plans/fees, absences, access, emergency procedures, third-party reimbursement procedures, termination and referral procedures, and advanced notice of the use of collection agencies, are discussed.

d) to a clear statement of the purposes, goals, techniques, rules limitations, and all other pertinent information that may affect the ongoing mental health counseling relationship.

e) to appropriate information regarding the mental health counselor's education, training, skills, license and practice limitations and to request and receive referrals to other clinicians when appropriate.

f) to full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible.

g) to obtain information about their case record and to have this information explained clearly and directly.

h) to request information and/or consultation regarding the conduct and progress of their therapy.

i) to refuse any recommended services and to be advised of the consequences of this action.

j) to a safe environment for counseling free of emotional, physical, or sexual abuse.

k) to a client grievance procedure, including requests for consultation and/or mediation; and to file a complaint with the mental health counselor's supervisor (where relevant), and/or the appropriate credentialing body.

l) to a clearly defined ending process, and to discontinue therapy at any time.

Heather R. Fisse-Repole, RMHCI, LMT, RYT, MS
Registered Mental Health Counseling Intern
Licensed Massage Therapist
Registered Yoga Teacher

HIPAA Notice of Privacy Practices

Effective July 1, 2010

This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Heather R. Fisse-Repole, RMHCI, LMT, RYT, MS at the contact information listed above.

Our Privacy Commitment to You: Your privacy is of utmost importance to me. The information I have about you will be held to the highest levels of confidentiality. I am required by law to give you a notice of or privacy practices and to maintain the privacy of your confidential information. Unless you give me permission in writing, I will only disclose your information when I am ethically or legally required to do so.

Who Will Follow This Notice: This notice describes the privacy practices followed by Heather R. Fisse-Repole, RMHCI, LMT, RYT, MS and all Jacksonville Health & Wellness Center (JHWC) staff.

Your Confidential Information: This notice applies to the information and records I have about your counseling, mental health status, and the care and services you receive.

Special Situations When I May Use and Disclose Information About You: I may use or disclose information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety:** I may use and disclose confidential information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person. I may also disclose information relative to the disclosure of past or present knowledge of child abuse or abuse of the elderly or the disabled.
- **Required By Law:** I will disclose health information about you when required to do so by federal, state or local law.
- **Lawsuits and Disputes:** If you are involved in a law suit or dispute, I may disclose information about you in response to a court or administrative order. Subject to all applicable legal requirements, I may also disclose information about you in response to a subpoena.

Other Uses and Disclosures of Health Information: I will not use or disclose your confidential information for any other purpose other than identified in the previous sections without your specific, written *Authorization.* I must obtain your *Authorization* separate from any *Informed Consent* I may have obtained from you. It you give me *Authorization* to use or disclose confidential information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, I will no longer use or disclose information about you for reasons covered by your written *Authorization*, but I cannot take back any uses or disclosures already made with your permission.

Your Privacy Rights: You have the following rights regarding health information I obtain about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy your health information, such as progress notes and billing records. You must submit a written request to Heather R. Fisse-Repole, RMHCI, LMT, RYT, MS to inspect and/or copy your information. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other associated supplies. I may deny your request to inspect/copy in certain limited circumstances. It you are denied access to your information, you may ask that the denial be review. If such a review is required by law, I will select a mental health professional to review your request and our denial.

The person conducting the review will not be the person who denied your request, and I will comply with the outcome of the review.

- **Right to Amend:** If you believe information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Record Amendment/Correction Form to the Heather R. Fisse-Repole, RMHCI, LMT, RYT, MS. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that:

☐ *I did not create unless the person or entity that created the information is no longer available to make the amendment*

☐ *Is not part of the information I keep*

☐ *Is accurate and complete*

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures I have made of confidential information about you. To obtain this list, you must submit your request in writing to the Heather R. Fisse-Repole, RMHCI, LMT, RYT, MS. It must state a time period, which may not be longer than six years and may not include dates before August 2012. Your request should indicate in what form you want the list, e.g., paper, electronic, etc. I may charge you for the costs of providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before the costs are incurred.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the confidential information I use or disclose about you. I am not required to agree to such requests.
- **Right to Request Confidential Communications:** You have the right to request that I communicate with you about treatment matters in a certain way or at a certain location. For example, you may ask that I only contact you at work or by mail. I will not ask you the reason for your request and will accommodate all reasonable requests.
- **Right to a Paper Copy of This Notice**: You have the right to obtain a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the office.

Changes to This Notice: I reserve the right to change this notice and to make the revised changed notice effective for confidential information I already have about you as well as any information I receive in the future. I will provide you with a summary of the revised or changed notice.

Complaints and Communications to Me: If you wish to communicate with me about privacy issues or if you believe your privacy rights have been violated and wish to file a complaint with our office, you can do so in writing to:
Heather R. Fisse-Repole, RMHCI, LMT, RYT, MS
9957 Moorings Dr., Ste. 403, Jacksonville, Florida 32257
You will not be penalized for filing a complaint.

Complaints and Communications to the Federal Government: If you believe that your privacy rights have been violated, you have the rights to file a complaint with the federal government. You may write to:
Office for Civil Rights
U.S. Dept of Health & Human Services
150 S Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111
Email: ORRComplaint@hhs.gov 3
You will not be penalized for filing a complaint with the federal government.

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