



Lyon Counseling, LLC  
661 Seminola Blvd.  
Casselberry, FL 32707  
321-430-5966  
jesse@lyoncounseling.care

**Client Information**

Client Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Education: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Years Married: \_\_\_\_\_  
Religion: \_\_\_\_\_ Active? \_\_\_\_\_

**Immediate Family:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

What is the presenting issue that brings you here today?

Previous Counseling/Psychotherapy (with whom and when)?



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**Medical Information**

Primary Care Physician (PCP): \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribed by & when: \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribed by & when: \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribed by & when: \_\_\_\_\_

History of Medical and/or Mental Illness:

Family History of Medical and/or Mental Illness:

Developmental and Family Dynamics History:

**Insurance Information**

Do you have out-patient mental health coverage benefits?      Yes      No

Name of Insured: \_\_\_\_\_ Family Benefits?      Yes      No

Insurance Company: \_\_\_\_\_ Policy No. \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_



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**FEES AND CHARGES:**

1. Counseling and Psychotherapy fees are \$150 per 45 - 50 minute session. Sessions exceeding 50 minutes, you may be billed proportionally.
2. Telephone consultation and other professional activities rendered on behalf of the client are also billed. Short telephone "check-in" or scheduling coordination phone calls are never billed.
3. Payment is due at the time of service.
4. You will be given a receipt for insurance purposes. The assignment of payment to the therapist instead of the policy holder is agreed to by your signature below.
5. Co-payments (\$\_\_\_\_) are sometimes established by your insurance company and will be due at the time of service.
6. In addition to the co-payment mentioned above, the balance of the fee not covered by your insurance is also billable. You will receive a statement including the amount due on your account, which is due at the time received.
7. Missed appointments, other than a genuine emergency or illness, will be billed at the rate of \$50 per occurrence, unless notification is made 24 hours in advance.
8. In a circumstance where problems are encountered in receiving payment for services rendered, you may be billed additional charges to cover the cost of time and expenses incurred to obtain payment.
9. For co-payments and payments made using a credit or debit card, a fee of \$5 per transaction will be applied. Payment made in the form of cash or check will not be charged this fee.
10. Services related to court cases, including preparation, conference calls and court appearances are billed at a fee of \$150 per hour and must be pre-arranged with the therapist.
11. Upon mutual agreement between therapist and client, letters of recommendation, assessment and for social security purposes can be written on the client's behalf. The therapist will provide these services at a charge of \$30 for a short, one page letter and \$50 for a longer more thorough letter.

I understand that Lyon Counseling LLC and its therapists are providing professional services to me and/or my family. I hereby agree to assume full financial responsibility for payment of all treatment charges incurred, as outlined above.

**Signature of Responsible Party(s):** \_\_\_\_\_ **Date:** \_\_\_\_\_



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### **Informed Consent**

I voluntarily agree to participate in counseling sessions and/or consent to the participation of my child or dependents in counseling. I understand that my therapist is a licensed professional at Lyon Counseling, LLC.

I understand these sessions are confidential and the Counselor will keep confidential anything the Client says with the following exceptions: (1) the Client directs the Counselor to tell someone else, (2) the Counselor determines that the Client is a danger to self or others, (3) the law requires disclosure, such as in the case of child abuse or when ordered by a court to disclose information, (4) information shared in confidence with a supervisor or professional colleague.

I understand that the primary modality of therapy will be “talk therapy”, which may sometimes include relaxation, deep breathing and hypnotherapy.

I understand that health insurance companies often require advance notice of services and that the Client be given a diagnosis providing a medical necessity for counseling or psychotherapy. I consent to the release of information and notification of my insurance company to determine benefits and to secure payment. I understand that any diagnosis will become part of my permanent insurance records.

I understand that services will be rendered in a professional manner consistent with the ethical standards that govern the profession and that I can discontinue counseling sessions at any time. I have had a chance to ask questions in advance and have my questions satisfactorily answered.

I also understand that all clinical information will be kept confidential, except as stipulated in Florida Statutes 39,394 and the Health Insurance Portability and Privacy Act (HIPPA), as described in the Privacy Notice. The clinical record is the property of, and will be retained by Lyon Counseling, LLC. Authorized personnel of Lyon Counseling, LLC may review my clinical record for the purpose of service provision, clinical supervision, consultation, auditing and compliance. Portions of my information will be used for billing and payment purposes. This notice will be kept for a period of seven (7) years.

I have knowledge of Lyon Counseling, LLC’s Client Rights and Responsibilities Policy. I have been given the opportunity to ask questions and I understand my rights and responsibilities. I have been informed by Lyon Counseling, LLC staff of the services available through Lyon Counseling, LLC and agree to participate.

I may revoke my consent, in writing, for any or all services at any time.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## 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 IT CAREFULLY.

This notice describes Lyon Counseling, LLC's privacy practices and that of:

- All staff or contractors authorized to enter information into your file, or provide you with mental health or life coaching services.
- All sub-contracted psychotherapists, counselors and providers of comprehensive assessments and services.

These entities may share your confidential health care information ("information") with each other for treatment, payment or other purposes described in this notice.

Your information may be released to other mental health professionals within Lyon Counseling, LLC for the purpose of providing you with quality healthcare.

Your information may be released to Medicare, Medicaid, an HMO, or other third parties for the purpose of Lyon Counseling LLC receiving payment for providing mental health services.

You and your legal guardian have the right to know who has accessed your information and for what purpose, if that access was provided outside the normal treatment and administrative operations of Lyon Counseling, LLC.

You and/or your legal guardian have the right to obtain a paper copy of this Notice of Privacy Practices upon request.

Lyon Counseling, LLC is required by law to protect the privacy of your information. It will keep confidential any and all information it receives and will provide you with a list of duties or practices that protect your information.

Lyon Counseling, LLC will disclose your information when required to do so by Federal, State or Local law.

Lyon Counseling, LLC will abide by the terms of the notice. Lyon Counseling, LLC reserves the right to make changes to the notice and continue to maintain the confidentiality of your information.

You have a right to complain to Lyon Counseling, LLC if you believe your privacy rights have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

**Jesse Lyon, Lyon Counseling, LLC, 661 Seminola Blvd., Casselberry, FL 32707, 321-430-5966**

No personal issues will be raised for filing a complaint with Lyon Counseling, LLC.

I, \_\_\_\_\_ have been informed of Lyon Counseling, LLC's Privacy Practices.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_