Dr. Carol L. Clark, P.A.

11651 W. Biscayne Canal Rd.
Miami, FL 33161

www.DrCarolClark.com
Counselor@DrCarolClark.com

305-891-1827
fax: 815-346-3476

You are coming to a home office. Please park in the carport next to the turquoise PT Cruiser. If another car is there, wait for it to leave and then pull in. If it does not leave by 5 minutes into your time, please call me at 305-773-8785. Also call or text me at this number if you need to cancel or reschedule your appointment. Please do NOT ring the bell until your appointment time. Thanks.

Directions:

From East Broward or North Dade:

Take I-95 south and exit on 125th St.
Turn left (east) and go to Griffing/NE 3rd Ave.
Turn right and go one block to the light at W. Dixie Hwy.
Turn right and go to the next light at NE 119th St/118th Tr.
Turn left and go to the end of the street.
Turn right on W. Biscayne Canal Rd.
11651 will be on the left.

From West Broward:

Take I-75 south to the end where it will turn into the Gratigny Expressway
Take the Gratigny until the end where it will turn into 119th St.
Go to the end – make sure you go straight across W. Dixie Hwy.
Turn right on W. Biscayne Canal Rd.
11651 will be on the left.

From South Miami :

Take I-95 north to 119th St.
Turn right (east) and go to the end – make sure you go straight across W. Dixie Hwy.
Turn right on W. Biscayne Canal Rd.
11651 will be on the left.

From Southwest Dade:

Take SR 826 (Palmetto) north to the Gratigny Expressway (just past exit for I-75).
Take the Gratigny until the end where it will turn into 119th St.
Go to the end – make sure you go straight across W. Dixie Hwy.
Turn right on W. Biscayne Canal Rd.
11651 will be on the left.

From Northeast of I-95, Aventura
Take W. Dixie Hwy to NE 125th St.
Go through onto NE 6th Ave.
Make an immediate right on NE 124th St.
Go to the end and turn left back onto W. Dixie Hwy.
Go to 119thSt/118th Tr (same thing) and turn left.
Go to the end
Turn right on W. Biscayne Canal Rd.
11651 will be on the left.

From Southeast of I-95, downtown Miami
Take Biscayne Blvd north and take the fork onto NE 6th Ave.
Go to just before the bridge to Biscayne Park. NE 111th St and W. Biscayne Canal Rd. will be on the left.
Turn onto W. Biscayne Canal Rd and go to 11651. It will be on your right.

From Biscayne Blvd
Take 123rd St west to NE 6th Ave (it will turn into NE 125th St.)
Turn left
Turn right on NE 124th St.
Turn left on West Dixie Hwy.
Turn left at light at NE 119th St/118th Terr.
Turn right on W. Biscayne Canal Rd.
11651 will be on the left.

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ACTIVITY AND BILLING RECORD

Client:		DOB:		Insured ID:	
Address:		SS:		Name:	
				DOB:	
Phone:		Employer:			
Email:		Insurance Plan:		Co-pay:	
Diagnosis:		# Sessions		Authorization #	
Card Number					
Expiration Date		V Code		Zip Code	

	DATE	TX	Client Fee	Amount Paid	Insurance Payment	Client Balance	NOTES
1							
2							
3							
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BASIC INFORMATION

Date: _____

Name: Age:

Best way to contact you: Home Phone: _____ Cell Phone: _____

E-mail _____

Restrictions on calling or email? _____

Employment/Type of Work:

Education:

Name of Significant Other:

Names and Ages of Children:

Emergency Contact: Phone:

Referral Source:

Previous Counseling or Psychiatric Experience: When? _____ With whom? _____

Describe briefly _____

Current Medications:

Are you currently experiencing feelings of wanting to hurt yourself? _____ Someone else? _____

Please describe: _____

Previous or past diagnoses:

Presenting Problem:

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AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I, the undersigned, request that the above named therapist provide professional services to me or my child/ward _____ as a client, and I agree to pay Dr. Clark's fee of $ _____ for an initial evaluation and $_____ per session (45-50 60 90 minutes) for these services.

If the patient is a minor, I understand that I have a right to the information my child shares with Dr. Clark and I will use this any information shared for the child's best interests.

If, at any time, I am dissatisfied with this therapy I will fully discuss my views, reasons and plans with Dr. Clark (and if the client is a minor, with the client named above) prior to terminating therapy.

I agree that this financial relationship will continue in effect with the Dr. Clark as long as she provides services or until I inform her in person, by telephone or by certified mail, that I wish to end it. I agree to pay for services rendered to myself or my child/ward up until the time I terminate the relationship.

I understand that I am responsible for charges for services provided by Dr. Clark to me or my child/ward, although other persons or insurance companies may make payments on my account.

CANCELLATION OR NO-SHOW POLICY

I understand that I must cancel an appointment 24 hours in advance to avoid a cancellation fee. I will be charged half of my usual session fee - _____- if I cancel between 24 and 2 hours prior to my appointment. I will be charged the full session fee of _____ if I cancel less than 2 hours prior to the session or if I fail to show up at all. The session fee is either the amount I self pay or the amount that the insurance company pays including my co-pay.

I agree to provide my credit card information and for my credit card to be charged the appropriate fee as indicated above in the event of a cancellation or no-show.

Signature: _____ Printed name: _____

Relationship to the patient: o Self o Other: _____ Date: / /

Credit Card #_____
Expiration Date: _____ Security Code _____ Zip Code: _____

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CONSENT TO TREATMENT

I, _____ DOB: _____, do hereby seek and consent to participate in treatment by Dr. Carol L. Clark, PA. I understand the nature of the treatment to which I am consenting and have been informed of the potential advantages and disadvantages of that treatment. I have had an opportunity to ask all my questions and have received satisfactory answers to all of my questions.

1. I have been given and fully understand information regarding my rights and responsibilities as Dr. Clark's client.

2. I have been given and fully understand information regarding the limits of confidentiality of my records.

3. I have been given and understand information regarding the cost of services from Dr. Clark. I understand and agree that I am responsible for all fees and co-payments, payable each time I come to treatment. I am aware that I may terminate my treatment at any time without consequence, but that I will still be responsible for payment for the services I had received. I am aware that if I have not paid for services received, my treatment may be discontinued by Dr. Clark.

4. I am aware that the development and review of my progress, or of a Treatment Plan, is in my best interest and may be required by governmental, funding, accrediting or other agencies and I agree to actively participate in this process.

5. I am aware that the practice of psychotherapy or counseling is not an exact science and so predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Dr. Carol L. Clark, PA.

6. I understand that I may address any concerns or grievances with Dr. Clark or any other representative of my insurance provider at any time. I understand that I may also contact the licensing board which regulates my therapist's professional practice.

7. **I am aware that any cancellations of appointments must be made more than 24 hours in advance of the appointment and if I do not cancel or do not show up I will be charged for that appointment**.

8. I am aware that Dr. Carol L. Clark, PA is not responsible for any personal property or valuables I bring into its facilities. I acknowledge that if I, or anyone else for whom I am legally responsible, deliberately causes damage or steals any property of this office, I will be held financially responsible for its replacement.

I certify, with my signature below, that I have read, had explained to me where necessary, fully understand, and agree with the contents of this Consent to Treatment.

Signature of Client or Parent/Legal guardian Date

Signature of Witness Date

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Name: _____ Date: _____

Symptom Check List
(Please circle all items you feel apply to you)

Heart palpitations	Irritability	Can't concentrate	Muscle tension
Nervous	Sleep problems	Restless	Headaches
Fatigue	Shaking	Worthless	Weight gain
Want to hurt myself	Cowardly	Crying a lot	Thoughts of death
Weight loss	No appetite	Depressed	No energy
No interest	Thoughts of suicide	Inadequate	Life is empty
Not confident	Can't make decisions	Hypervigilant	Panicky feelings
Guilty	Distressing memories	Easily startled	Memory problem
Nightmares	Angry	Tense feeling	Reckless
Unable to relax	Easily startled	Detachment	Shameful
Don't take vacations	Intelligent	Shy	Pushy
Confused	Fainting spells	Stupid	Misunderstood
Considerate	Sympathetic	Evil	Timid
Deformed	Alcohol problems	Overambitious	Confident
Worthwhile	Financial problems	Good person	Drug problems
Incompetent	Regretful	Dizziness	Can't keep a job
Can't make friends	Horrible thoughts	Attractive	Home conditions bad
Stomach trouble	Hateful	Lonely	Sex problems
Unattractive	Inferiority feelings	Unloved	Naïve
Out of control	Compulsive	Bored	Impulsive

Add any other words, thoughts, feelings that _____

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Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Client Name:_____

DOB:_____ Date of Intake:_____

SSN:_____ ____ _____

I acknowledge that I have received and have been given an opportunity to read a copy of the **Notice of Privacy Practices** for Dr. Carol L. Clark, PA. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Clark at 305-891-1827.

_____

Client Signature Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

Witness Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

If a client's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to the client and sign below.

Client Refuses to Acknowledge Receipt:

Presented on: Date_____ Time_____

_____

Signature of Staff Member

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NOTICE
of
Privacy Practices

Summary of Notice

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

Please review carefully

Federal Law, specifically the Health and Information Portability and Accountability Act (HIPAA), requires that I describe for you my medical privacy practices and your rights as a client under the law.

This notice brochure is a summary of the complete notice that has been made available to you in the waiting room.

If you have any concerns about your medical privacy, please call me at:
305-891-1827

How I may use your Protected Health Information.

I create and receive Medical information about you as a part of your care. This information is called protected health information , or PHI. It is personal and private. I may use this information in many ways. I release only the information necessary to accomplish a task.

First, I use the information when I treat you or refer you for treatment. I may communicate with other professionals and referral agencies.

Second, I may use the information to submit bills for your medical care to insurers, Medicare, or third party payers.

Finally, I may use this information for my health care operations. This means the work I must do to provide quality services to you and all of my clients.

I will seek your authorization when state or federal law requires it.

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I may use PHI without your permission for the following reasons.

- As required by state or federal law.
- For public health purposes, such as reporting child or elder abuse, or if you are a danger to yourself or to others.
- To treat you in an emergency.
- To inform you of alternative treatments.
- When ordered by a regulatory agency, such as Health and Human Services.
- For law enforcement purposes or in response to a court order.
- For agencies involved in a disaster situation.
- To communicate with coroners, medical examiners, and funeral homes when necessary.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with correctional officials if you are an inmate.
- To carry out treatment and billing operations through a billing or transcription service.
- Your authorization is required for other disclosures.

The following PHI receives special protections under federal and/or state law.

- Psychotherapy Notes are kept separate from the medical record and receive special protection.

- Psychotherapy Notes exclude medication prescription and monitoring, counseling session start and stop time, the modalities of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

- Alcohol and drug abuse information have special privacy protections. I will not disclose any information identifying an individual as being a client or provide any mental health information unless:

1) The client consents; 2) A court order requires disclosure of the information;
3) Medical personnel need the information to meet a medical emergency; 4) Qualified personnel use the information for the purpose of conducting research management audits, or program evaluation; or 5) It is necessary to report a threat to commit a crime or to report abuse or neglect as required by law.

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Your rights to access and control your PHI

You have the following rights regarding your protected health information (PHI), provided that you make a written request.

- Right to request restriction. You may request limitation I may disclose, but I are not required to agree to your request.
- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
- Right to inspect and copy. You have the right to inspect and copy your Mental Health information regarding decisions about your care: however, psychotherapy notes may not be inspected and copied, although I may provide a summary. I may charge a fee for copying, mailing, and supplies.
- Right to request clarification of the record. If you believe that the PHI I have about you is inaccurate, you may ask to add clarifying information. I am not required to accept the information that you propose.
- Right to accounting of disclosures. You may request a list of the disclosures of your Mental Health information that have been made to entities other than for routine treatment, payment, or healthcare operations.

Complaints

If you believe your privacy has been violated, you may file a complaint with me or with the Department of Health and Human Services at **1-877-696-6775.**

You will not be penalized or retaliated against in any way for making a complaint.

I am required to provide you with this Notice that governs my privacy practices. I will provide any forms necessary to enforce your rights.

Florida Statute. Florida statutorily grants clients the right of access to medical records maintained by health care practitioners. The disclosure of client information by providers is generally prohibited without the client's consent, subject to specified exceptions.

Florida also has numerous laws protecting the confidentiality of health information held by a variety of entities and government agencies.