Good Mental Health
COUNSELING & COACHING

Consent for Treatment

Client Name____DOB_____/_____/_______

If Minor, Parent Name ____

Address____

City____State__________Zip_________

PH#/Cell (_____________)____

Email____

Emergency Contact Person____

PH#__(______)____________________Relationship to Client____________________________________

Reason for seeking services____

____

How were you referred? ____

Do you consent to receiving? (please circle) Phone calls Emails Text Messages

Mental Health History____

Do you see a Psychiatrist? Y N If yes, who?____

Meds currently taking ____

____

I hereby authorize Good Mental Health LLC to speak to the following people regarding my care, payments, and upcoming appointments____

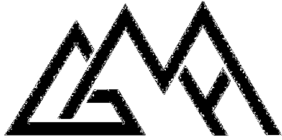
____

Your Responsibilities as a Therapy Client

Please Initial:

______________You are responsible for keeping track of and coming to your appointments at the scheduled time. Sessions last for 50 minutes. If you are late, we will end on time and not run over into the next person's session.

______________Due to the unique nature of teletherapy (meeting via video chat) , you are responsible for communicating your physical location at the beginning of each meeting. In the event you are experiencing crisis, this information will allow me to access the proper intervention necessary to support your well-being.



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Consent for Treatment, continued from previous page

Please Initial:

______________Your appointment is set especially for you. If you cannot make your appointment, please notify me as soon as possible at hello@goodmentalhealthllc.com or 904-419-7435. This allows me to fill the appointment and prevents long wait times between appointments. For appointments canceled less than 24 hours in advance, a telephone or teletherapy appointment will be made available for you at the appointed time, however you will be charged your normal session rate whether or not you choose to attend.

______________If you miss an appointment without notification, you consent to a $72 no show fee due before you are seen again. If you miss 2 or more appointments without notification you will be referred to a new provider and I will no longer provide you services.

______________You agree to pay for your portion in full at the beginning of your appointment. My fees are listed on the SERVICES page of my website (goodmentalhealthllc.com) and include $72/session for teletherapy, $72/session in office. I can accept payment online through the secure payment portal on my website or in-person via check, cash, or credit card. At this time, I do not accept private insurance but I am willing to work on a sliding fee scale for those in need. I require an authorized credit card on file to insure against missed appointments and will always notify you when charging your card.

______________I am not willing to have clients run a bill with me. You agree to pay any and all monies owed. If you refuse to pay any debt with Good Mental Health, LLC, you consent to have your name given to a collection agency to recover any debt and services will be terminated.

I have received and read the Disclosure Statement and my responsibilities as a client and had any questions answered to my satisfaction. By my signature below, I verify that I understand the Disclosure Statement and my responsibilities as a client and consent to participate, or have my child participate, in treatment with Good Mental Health, LLC. If attending Couples Therapy, I understand that my/spouse's signature(s) indicate that I/we give consent to release to my spouse any and all information discussed in session with my spouse present. I consent to the disclosure of necessary information to my insurance company for billing purposes if applicable.

____

Client/Parent Signature Date

____

Spouse Signature (if applicable) Date

____

Diana Brummer, MSW, LCSW Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us at hello@goodmentalhealthllc.com. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ________________________________
Cardholder Name (as shown on card): ________________________________
Card Number: ________________________________ CVV Code: ________________
Expiration Date (mm/yy): ________________________________
Cardholder ZIP Code (from credit card billing address): ________________________________

I,______________________________ , authorize **Diana Brummer with Good Mental Health LLC** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

____ ____

Customer Signature Date

Welcome to Good Mental Health, LLC. We are a mental health counseling and wellness coaching practice based in St. Johns, Florida. My name is Diana Brummer and it is my pleasure to provide you with professional counseling and coaching services. It is my goal to assist individuals and their families by providing genuine support and to teach coping tools in a caring and confidential manner designed to help you handle life's challenges.

I am a Licensed Clinical Social Worker in the State of Florida which means I completed a Masters Degree Program and met the necessary requirements to receive clinical licensure in the State of Florida. I received a Bachelor's Degree in Psychology from Florida State University in 1997. Shortly after, I entered the field and have been working in mental and behavioral health, social work, and mind-body wellness for over 20 years. I returned to Florida State University in 2014, receiving my Masters in Social Work in 2016. I successfully completed the mandatory requirements for clinical licensure in July 2019. It is my most sincere desire to help you by teaching you, and/or your child, strategies to change thought and behavior patterns related to the things that cause you pain as well as learn to let go of things that you cannot control but may cause you stress. I can also help you have better relationships and be a better communicator, partner, parent, or employee. For more information regarding my specialties and/or experience, please refer to my website https://goodmentalhealthllc.com.

The following Disclosure Statement provides a detailed explanation of my practice.

My Responsibilities to You as Your Therapist

Confidentiality

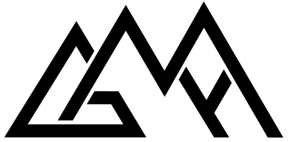
With the exception of certain specific circumstances, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone what you have told me or that you are/not in therapy with me without your prior permission in writing. I will always act to protect your privacy even if you release me in writing to share information about you. You may direct me to share information with whomever you choose and you can change your mind and revoke that permission at any time.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability act (HIPAA) and Federal and Florida Law 42 C.F. Part 2 and 2.22. This law ensures the confidentiality of all written and electronic transmissions of information about you. Whenever I transmit information about you electronically it will be done with special safeguards to ensure confidentiality.

If you elect to communicate with me by email or text, please be aware that it is not completely confidential. All emails are retained in logs of your or my internet provider. While under normal circumstances no one looks at these logs they are, in theory, available to be read by the system administrator of the internet service provider. Any email I receive from you, as well as any responses that I send you will be archived and kept as part of your electronic medical record. In order to provide you with confidential electronic communication in the form of video chat or text messaging, clients will be invited to my private, HIPPA compliant online office space.

There are certain legal exceptions to confidentiality of which you should be aware. I will tell you if I am required to take action in response to one of these exceptions. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone who is doing this, I must inform Child Protective Services or Adult Protection Services. If I believe you are in imminent danger of harming yourself or someone else, I may legally break confidentiality and call the police or local crisis team. I would explore all other options with you before taking this step.

If you have a life threatening or potentially disabling medical emergency in my presence, I am required to release to medical personnel the minimum information necessary to assist you medically.



A court of law can request and obtain information without your consent. Or, if you have been court-ordered to treatment, the judge may set aside your right to privileged communication. I will not automatically release information that has been requested by a court unless it is deemed necessary and compliant with the law.

I keep very brief records, noting only that you have been seen, what interventions occurred in sessions and topics we discussed. You have the right to a copy of your file at any time, giving me the chance to furnish you with that copy. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

Diagnosis

Diagnoses are technical terms used to describe the nature and scope of your presenting issue. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the DSM-5; I have a copy in my office and will be glad to discuss your diagnosis with you. Insurance companies usually require a diagnostic code called an ICD-10 code (as of October 2015) in order to process your insurance claim. A diagnosis is determined after assessing your present and past level of functioning.

Managed Mental Health Care

If you have mental health benefits as part of your health insurance coverage, you must call for your benefit information prior to our first appointment if you would like to receive any reimbursement for my fee. You need to find out if you have a copay or % that you are responsible for as well as any deductible. Since I do not accept private insurance at this time, I cannot bill your insurance provider for you but I am happy to provide you with an invoice for my services which you may submit for reimbursement.

Complaints

If you are unhappy with what is happening in therapy, I strongly encourage you to speak about it with me so that I can respond to your concerns. I will take your concern seriously and respond with care and respect. If you believe that I have behaved unethically, you can complain to the Medical Quality Assurance Board of the State of Florida at www.myflorida.com or file a written complaint to the Department of Health/ Consumer Services Unit, 4052 Bald Cypress Way, Bin C75, Tallahassee, FL 32399-3275.

My Approach to Counseling

I practice an evidence-based counseling modality called Cognitive-Behavioral Therapy. The premise of this theory is that we are influenced by our thoughts as we experience things and this effects how we react, or behave, relative to those experiences. My work is heavily informed by Family Systems and Attachment theories, which describes how our interpersonal relationships during childhood effect our relationships later in life. If you have any further questions about my practice style, I am happy to answer any questions you may have. Some techniques I use are shifting negative thought patterns through identifying thoughts of lack and shifting them to more affirmative thoughts. I teach healthy interpersonal boundaries and communication tools. I may suggest that you participate in a support group or see a medical doctor for a medical evaluation. This is typically done by a psychiatrist who prescribes medicine specifically for mental health disorders. I cannot prescribe medication. You can refuse any suggestions I make. I must limit social relationships with current or former clients because it is unethical. If we see each other in a public setting, out of respect for your confidentiality, I will not acknowledge you unless you approach me first.

There are certain emotional risks associated with the counseling process. Approaching feelings or thoughts that you have tried not to think about may be painful. Making changes to your beliefs or behaviors can be frightening and sometimes disruptive to the relationships you already have. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

Therapy will end when you decide it is time for it to end unless another arrangement is made, such as a contracted number of sessions. You may bring whomever you wish into your therapy. I may terminate you if you do harm to, or threaten to harm me, my family, or my staff.