Heart Mind Soul Services, PLLC
Charla Ogaz Almeida, PhD, MA, LPCc,
10 Boulder Crescent, Suite 300G
Colorado Springs, CO 80903

Full name: _____

Address: _____

_____

City: _____ State: _____ Zip:_____

Birthdate: _____ Age: _____

Sex: _____

Home phone: _____

Cell phone: _____

Email: _____

Occupation/Employer: _____

Emergency Contact's Name: _____

Emergency Contact's Phone: _____

Emergency Contact's Relationship: _____

Current Medications: _____

_____

Physician Diagnosed Medical Problems:

_____

Have you ever been treated or diagnosed with Alcoholism/Alcohol Abuse/Drug Addiction/Drug Abuse?

_____

Client Goals:

Background Information:

Client/Family Strengths:

Disclosure Statement for
Heart Mind Soul Services, PLLC
10 Boulder Crescent, Suite 300G
Colorado Springs, CO 80903

In providing therapy, I seek to engage a process of listening to the heart, mind and soul of the client to move towards an integrated whole. I believe healing and health occur at multiple levels and am willing to consider the feeling nature, the mental scripts, the behaviors, and the soul's purpose in counseling. I work in a collaborative manner to help you achieve the changes you desire in your life.

Parking

Street parking is available on Boulder Crescent, both metered and unmetered. Clients are not permitted to park behind the building.

Young Children

Please do not leave young children unattended in the waiting room. I cannot be responsible for their safety. Therapeutic work requires quiet, self-directed contemplation in order to be successful; therefore, please make necessary childcare arrangements elsewhere to cover your appointment time here.

Crisis Calls

In the event of a personal crisis, clients may call me at 719-299-7708. I will return calls as soon as reasonably possible; please leave a message if you reach my voicemail. In the case of an emergency, please call 911.

Non-Crisis Calls
To leave a non-crisis message, to cancel or change an appointment with me, please call 719-299-7708 or email at charla@heartmindsoulservices.com

On the following page you will find information that will ensure that your needs as an informed client are met. This includes my training, professional background and theoretical orientation and approach to counseling, the rights of clients in counseling, and information about confidentiality.

Training and Professional Background

I received my Bachelor of Arts degree from University of Colorado, Colorado Springs in Philosophy in 1991; my first Master's degree (1995) and doctorate (2000) from the University of California, Santa Cruz in History of Consciousness; my Master's degree in

Counseling Psychology in 2015 and my certificate in Positive Psychology coaching in 2016. My first career was teaching Women's Studies and Humanities at the college level as an assistant professor. I am currently a candidate for the License in Professional Counseling (permit # 0014607) with the State of Colorado. During the time in which I hold this permit, I am under the supervision of another Licensed Professional Counselor and share clinical information with him about my clients, anonymously. This is to say that the details of my cases might be shared between the two of us to review goals and progress but the client's identification remains confidential with me.

Theoretical Orientation and Approach to Counseling:

My approach to counseling is "eclectic," which is widely understood to mean using a variety of treatment models to help you zero in on your feelings, thoughts, and behaviors and the places where you would like to discover more or transform. The methods I use include Adler's theory of psychodynamics in relation to others; Attachment theory; Emotion Focused Therapy; Reality Therapy; Rational Emotive Behavior Therapy (REBT); Feminist Therapy; Solution-Focused Therapy, and finally, strengths-based Positive Psychology coaching.

The rights of clients in counseling

It is appropriate and important for clients to raise questions about the counselor, the therapeutic approach, the progress of the therapy and the cost. As informed consumers, it is the client's responsibility to choose the counselor and counseling modality which best suits their needs. Clients have the right to request a change in counseling approach, referral to another counselor or termination at any time.

All therapists are bound by the ethical codes of their professional organizations and the laws of the State of Colorado, as well as by regarding the special nature of the therapist-client relationship. All counselors must remain aware of the influential position they hold in the relationship with clients, using this influence in a constructive way. If a client thinks his/her therapist is not meeting this ethical responsibility, s/he is strongly encouraged to address this with the therapist and/or bring it to the attention of the licensing board for Professional Counselors (LPC) at the State of Colorado's Department of Regulatory Agencies (DORA).

I keep a record of the health care services I provide. You may ask to see and copy that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so.

Confidentiality

Counseling sessions are held in strict confidence. It is the client, not the therapist, who determines whether information may be released to anyone besides the client, and only then with a release signed by the client. Exceptions to this rule: state law mandates that there is no confidentiality where child abuse or abuse of a developmentally disabled adult has occurred within the last seven years. I may also be required to break confidentiality in life-threatening situations where the client poses a clear and present danger to self or others or is unable to provide minimum life-sustaining self-care. In these cases, I would take necessary steps to secure the safety of the client or others.

I have received and read the Disclosure Statement for Heart Mind Soul Services, PLLC.

Client Signature _____
Date_____

Therapist Signature _____
(Charla Ogaz Almeida)

By my signature below, I acknowledge that I received a copy of the Notice of Privacy Practices for Heart Mind Soul Services, PLLC.

Client Signature _____
(Or Personal Representative)

Date _____

Client Signature _____
(Or Personal Representative)

Date _____

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name:

_____

Relationship to Client: _____

You will receive one copy of this form and one will be kept in your HMSS record.

Charla Ogaz Almeida, PhD, MA, LPCc
10 Boulder Crescent, Suite 300G
Colorado Springs, CO 80903
(719) 419-8026

Notice Of Privacy Practices

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. The privacy of your information is of great importance.

The law requires that your protected health information (PHI) is private in accordance with this Notice of Privacy Practices (Notice), as long as this Notice remains in effect. A paper copy of this Notice must be provided to you which contains privacy practices, legal duties, and your rights concerning your PHI.

Revisions may be made to the privacy practices and the terms of the Notice at any time, as permitted or required by applicable law. Such revisions to the privacy practices and the Notice may be retroactive. The Notice will be updated and made available to clients prior to any significant revisions of the privacy practices and policies.

Covered by this Notice

This Notice contains the privacy practices of Heart Mind Soul Services, PLLC and Charla Ogaz Almeida, PhD, MA, LPCc, and sites maintained for delivery of counseling and consulting services. They may use and disclose your PHI as deemed appropriate for your treatment, payment, or health care operations.

Privacy Practices

Use And Disclosure

Your PHI may be disclosed for treatment, payment, or as required by other health care entities. For your convenience, the following examples of such potential uses or disclosures have been provided:

Treatment: Your PHI may be used by, or disclosed to, other health care workers involved with services provided to you.

Payment: Your PHI may be used or disclosed to collect payment for services provided to you.

Other Health Care Entities: Your PHI may be used or disclosed in order to satisfy the requirements of your EAP program, HMO, or PPO.

Authorizations

Your medical information will not be disclosed for any reason except those described in this Notice, unless you provide us with a written authorization to do so. A request may be made for authorization to use or disclose your PHI for any purpose, but you are not required to give such authorization as a condition of your counseling. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access

You are provided access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, your PHI may be disclosed to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if it is determined to be reasonably necessary, or in your best interests, for certain purposes such as allowing a person to act on your behalf.

Locating Responsible Parties

Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If determined with reasonable professional judgment you are capable of doing so, you will be given the opportunity to consent to, and to prohibit and restrict, the extent and recipients of such disclosure. If it is determined that you are unable to provide such consent, the amount of your PHI disclosed will be held to the necessary minimum.

Disasters

Your PHI to may be disclosed to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required By Law

Your information may be disclosed when required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, limited disclosures of PHI directly to law enforcement officials or correctional institutions may be made regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes.

Your PHI may be disclosed to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. Your PHI may also be disclosed when necessary to assist law enforcement offficials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons

After your death, disclosure of your PHI to a coroner, medical examiner, funeral director, or organ procurement organization may be made in very limited circumstances.

Research

Your PHI will not be used by Heart Mind Soul Services, PLLC or Charla Ogaz Almeida for research purposes unless specifically authorized by you.

Military and National Security

Information of Armed Forces personnel may be disclosed to military authorities under certain circumstances when required by law for intelligence, counterintelligence, and other national security activities.

Your Individual Rights

Access and Copies

In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to Charla Ogaz Almeida. Please contact him regarding copying fees.

Disclosure Accounting

You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the sections above: Use and Disclosures, Facility Direc- tories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to one free copy of an accounting about details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure account-ing more than once in a 12-month period, you will be charged a reasonable, cost-based fee for each.

Additional Restrictions

You may request additional restrictions on the use, or disclosure, of your PHI, but there is no legal requirement to honor such a request. Heart Mind Soul Services, PLLC and Charla Ogaz Almeida will be bound by such restrictions only if agreed to in writing and signed by Charla Ogaz Almeida.

Alternate Communications

You have the right to request that communication with you about your PHI by alternative means or alternative locations. Any reasonable request will be accomodated if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI

You have the right to request amendments to your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, your request may be denied but you will provided with a written explanation of the denial. You have the right to send a statement of disagreement to which a rebuttal may be prepared, a copy of which will be provided to you at no cost. All paperwork, or copies thereof, regarding your request will be kept in your file. Please contact Charla Ogaz Almeida with any questions about amending your records.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Charla Ogaz Almeida, or the Secretary of the U.S. Department of Health and Human Services. Your right to protect the privacy of your PHI or your right to file a complaint will be respected.

The following page, Page 3 of 3 of the Notice of Privacy Practices, is the Authorization for Release of Protected Health Care Information Form

Charla Ogaz Almeida, PhD, MA, LPCc
10 Boulder Crescent, Suite 300G
Colorado Springs, CO 80903
(719) 419-8026

Authorization for Release of Protected Health Information (PHI):

The undersigned client ("Client") or legally authorized representative ("Representative") hereby authorizes Charla Ogaz Almeida, PhD, MA, LPCc to use the Patient's Protected Health Information ("PHI") described on the lines below or to release such PHI to the following individuals, and their agents, employees, and assigns ("Recipients"):

(Please list all names of persons, agencies, and entities or mark with "NONE")

The Client understands and agrees that the PHI to be used or released includes any and all acts, records, and opinions related to the Client's counseling and condition. (Please list or enter "ALL INFORMATION.")

The purpose, reason, or necessity of the use or disclosure of the above described PHI is as follows:

I, the undersigned Client or Representative, certify that I have read and understand this Authorization and that I am legally competent to sign this Authorization on behalf of myself or the Client.

(Date)

(Authorized Signature) (Printed Name)

(Representative Capacity / Attach appropriate documentation)

Send Revocations of Authorization to Charla Ogaz Almeida at the address given above.

No Show or Late Cancellation Policy for

Heart Mind Soul Services, PLLC
10 Boulder Crescent, 300G
Colorado Springs, CO 80903

1. I understand that I will be charged a LATE CANCELLATION fee of $25 if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will charged a NO SHOW fee of $25 if I fail to show for my appointment.

3. I understand that I will be charged a $10 service charge if I fail to make my payment the day of the appointment. Payment is possible by cash, check, PayPal on our website or credit card in office.

4. I understand that the therapy appointment will last 50 minutes. I understand if I am late for my appointment, I will still have to end the session at the allotted time.

5. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

_____

Signature of Responsible Party

_____

Printed Name of Responsible Party

_____

Date