Thoughtful Counseling LLC
5147 South Lakeland Drive, Suite 4
Lakeland, Florida 33813
(863) 701-5127

Professional Disclosure Statement

Thank you for selecting me as your Professional Mental Health Counselor.
This document is to inform you of my professional practice model and credentials.

Counseling Perspective

Thoughtful Counseling LLC provides services to individuals, adolescents, and families in the areas of ADHD/ADD, anxiety, depression, family issues, anger, behavior management, stress management, grief, life stressors, adjustments issues, and behavioral assessments.
Group seminars/Workshops for parents, teachers and professionals are also available.

"It is my desire to counsel in such a manner that I may help those I counsel to grow in a manner that will lead them to a positive future. I believe that all who seek counsel do so in order to improve their life and the lives of all they love. My theoretical approach is Cognitive Behavioral Therapy (CBT). In therapy you will learn why you feel the way you do and how to manage these feelings. Behavior is a learned choice. New and more pro-social behaviors are explored and integrated slowly as you explore the reasons for previous behaviors and feelings.

Some clients will need only a few sessions to see progress while others may require months or even years of a counseling relationship. I believe that we all have the potential to lead a happy productive life and that there are times when we need someone to help us meet our goals. I welcome all who seek my counsel without prejudice to race, religion, ethnicity, or sexual orientation."

-Denise J Norgan MA LMHC

Degrees and Qualification Experience

- Master of Art in Guidance and Counseling
  - University of South Florida -2001
- Bachelor of Art in Elementary Education
  - University of West Florida – 1990
- Licensed Mental Health Counselor in the State of Florida; MH8289
- Mental Health Counselor Supervisor of Interns in the State of Florida
- Certified by State of Florida as Regular Classroom Education
  - Grades 1-6, Social Sciences 6-12, Guidance and Counseling K-12
- Board Certified Professional Counselor by the American Psychotherapy Association.
- School counselor since 1999
- Private practice since 2005

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Risk of Therapy

Some clients may experience or need to experience unpleasant emotions as we explore the issues that brought them to therapy. Please know that therapy/counseling is not without risk of experiencing some unpleasantness. I will never allow anyone to leave a session in a state that I deem dangerous to their mental health. Your trust in me and your confidentiality is of the utmost importance to me. I will not break confidence unless your life or someone else's in danger.
While in therapy, as you Grow Toward a Positive Future know that I will be with you every step of the way.

Acknowledgement and Signature

By signing below, I acknowledge that I have reviewed the counseling perspective, degrees and qualifications of Denise J Norgan MA LMHC of Thoughtful Counseling LLC. I understand the risk of therapy and agree to proceed with counseling through Thoughtful Counseling.

I acknowledge that Denise J Norgan MA LMHC reserves the right to refer to other health care providers if she feels that she cannot be effective in your search for mental health.

I also acknowledge that Denise J Norgan MA LMHC of Thoughtful Counseling LLC has **the obligation to enact the Baker act if she assesses I am a danger to myself or others.**

Client Name: _____

Client Signature: _____

Date: _____

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PLEASE PRINT LEGIBLY

CHILD INTAKE

Child's Name: DOB:

Age: Sex: Race: Gender:

Child's Address:

Contact Number:

Relationship of Contact:

Child is currently living with:

Mother's Name: Father's Name:

Stepparent's Name (if applicable):

Stepparent's Name (if applicable):

Child's Siblings Names and Ages:

If child is adopted, please give pertinent information:

Please describe the situation/symptoms for which you are seeking help:

What would you like to see accomplished in your child's counseling:

Current/past use of alcohol/drugs? ☐ Yes ☐ No

Have you ever used drugs for other than medical purposes? ☐ Yes ☐ No

Legal involvement? ☐ Yes ☐ No

Have you ever been arrested? ☐ Yes ☐ No

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Suicide Attempts or Suicidal Ideation? ☐ Yes ☐ No

Current or past self-injurious behavior? ☐ Yes ☐ No

If Yes to any previous questions, please elaborate:

My child spends _____hours a day watching TV.

My child spends _____hours a day playing video.

My child spends _____hours a day using the computer.

My child spends _____hours a day reading.

Has your child previously participated in counseling? ☐ Yes ☐ No

Agency/Practice: Name of Therapist:

What was the result?

ACADEMIC HISTORY

School: Grade:

Describe Child's Academic Progress:

Does your Child have and IEP? ☐ Yes ☐ No

Was child retained? ☐ Yes ☐ No If yes, what grades?

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MEDICAL/SOCIAL HISTORY

Pediatrician's Name:

Allergies:

Please list any current medical concerns or medications:

Please list any past medical concerns or medications:

Please list any developmental concerns (feeding, sleep, anxiety, motor/language/social developmental problems, toilet training, etc.):

Please list any social/emotional concerns: (being bullied, bullying, sleep, anxiety, or fears, etc.):

FAMILY HISTORY

Family Stressors (current factors that are a source of stress in the family):

Family Structure (who lives in the current household/relationship to the child):

Family Development (marriages, separations, divorces, deaths, traumatic events/losses

Parent's Current Marital Status:

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MOTHER'S HISTORY

Mother's Age: Work status: Highest Grade Completed:

Learning/Behavior Concerns:

Please describe current marriage/relationship (if applicable):

Please describe any past relationships/marriages (including length of previous marriage/ relationships):

Medical concerns:

Mother's childhood atmosphere (family position, abuse, illness, etc.):

Please specify any current or past mental health treatment, alcohol/drug abuse history, psychiatric treatment, suicide attempts, and hospitalizations:

FATHER'S HISTORY

Father's Age: Work status: Highest Grade Completed:

Learning/Behavior Concerns:

Please describe current marriage/relationship (if applicable):

Please describe any past relationships/marriages (including length of previous marriage/ relationships):

Medical concerns:

Father's childhood atmosphere (family position, abuse, illness, etc.):

Please specify any current or past mental health treatment, alcohol/drug abuse history, psychiatric treatment, suicide attempts, and hospitalizations:

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AKNOWLEDGEMENT

By signing below I acknowledge that everything that I have provided in this intake form is true and accurate to the best of my knowledge.

Name of individual completing form:

Relationship to Client:

Signature: Date:

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PARENTAL CONSENT FORM

I (we), _____, give permission for Denise J Norgan, MA, LMHC: *Thoughtful Counseling LLC* to render therapeutic services/treatment to my child(ren) or ward(s).

_____ _____
Child's Name Child's DOB

_____ _____
Child's Name Child's DOB

_____ _____
Child's Name Child's DOB

_____ _____
Child's Name Child's DOB

_____ _____
Parent's Printed Name Date

_____
Parent's Signature

_____ _____
Parent's Printed Name Date

_____
Parent's Signature

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INSURANCE INFORMATION

Client's Name: _____ DOB: _____

Client Address: _____

_____

Phone: _____

Insured's Name: _____ DOB: _____

Relationship to Client: _____

Insured's Address: _____

_____

Phone: _____

Insurance Company: _____ EAP: ☐ Yes ☐ No

Sessions authorized: _____ Copay: ☐ Yes ☐ No Amount: _____

Insured's ID Number: _____

Insured's Group/Policy Number: _____

Authorization Number: _____ _____

Billing Address of Insurance Company: _____

_____

Insured's Company/Employer: _____

Sessions authorized: _____

LYRA 9-digit CODE (If applicable): _____

I, _____, authorize *Thoughtful Counseling, LLC* to file claims with the above insurance for services provided.

Print Name: _____ Date: _____

Signature: _____

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Treatment Interfering Behavior Form Acknowledgement

Treatment interfering behavior (TIB) are patterns of behavior over several sessions of therapy or counseling. These are not isolated incidents in one session. Missing one session is not necessarily a problem, but missing several sessions over time would be considered a TIB. The intention of behavior may or may not be to sabotage therapy. Either way the outcome could prevent someone from overcoming the problem they sought out help for initially. Examples of TIB can include but are not limited to:

- Not acknowledging they have a problem.
- Doesn't consistently acknowledge the problem' severity or its impact on others.
- Does not identify clear goals for treatment.
- Arguing or dismissive behavior with the counselor.
- Interjecting the conversation with topics not related to the treatment plan.
- Difficulty answering questions in a timely manner as to stall the session.
- Providing inaccurate or misleading information to the counselor.
- Not complying with therapy.
- Frequently late or "No call, no show" to therapy.
- Engages in, threatening or hinting at self-destructive acts.
- Speaking in a tone or manner that makes members of the counselor feel threatened.
- And others are not listed.

I understand that patterns of behavior during therapy could inhibit my ability to achieve my treatment goal.

Client Name: _____ Date: _____

Client Signature: _____

Original form Developed at Saint Louis Behavioral Medicine Institute, St. Louis, MO, An Affiliate of Saint Louis University Health Sciences Center.

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Counseling Services Agreement

Please read the following statements carefully and acknowledge with your initials.

_____ I understand the expectations, policies, and procedures of Denise J Norgan's practice, *Thoughtful Counseling LLC*.

_____ I have been given adequate opportunity to clarify my expectations and otherwise address any questions that I have about these policies and procedures.

_____ I agree to accept and abide by the policies and procedures as I obtain counseling services through Denise J Norgan's practice, *Thoughtful Counseling LLC*.

_____ I specifically understand and accept my rights and responsibilities related to privacy, scheduling and cancellation of services, and payment of professional fees. I request that counseling services be initiated for me.

____ I understand that Denise J Norgan of *Thoughtful Counseling LLC* is **obliged to enact the Baker Act if assesses I am a danger to myself or others.**

____ I understand that Denise J Norgan of *Thoughtful Counseling LLC* is unavailable outside of business hours. I will call the **Mental Health Hotline at 988, or Peace River Center Crisis Line at 863-519-3744, or 911 should I need assistance**.

____ **I understand that no FMLA paperwork will be completed as part of the counseling services offered under this agreement**

_____ I agree not to call Denise J Norgan of *Thoughtful Counseling LLC* as a witness in any litigation or legal proceedings. Note: Should you compel me to provide information in a court proceeding or elsewhere, you agree in advance that you will compensate me, at the rate of $200/hour, for all time expended in response to the request for release of information, phone consultation, and preparation of documents. If at any time, I should be called to testify in court, you agree to compensate me $300/hour including preparation of documents, phone consultation, court time, and all travel time (portal to portal), plus cost of any legal services which I may employ.

In response to my request for counseling services, I have received and reviewed the policies of this office. My initials indicate my understanding of the statements above and I agree to the terms of Counseling with Denise J Norgan of *Thoughtful Counseling LLC.*

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date

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Payment Policies and Financial Agreement

Thank you for choosing Thoughtful Counseling LLC for your counseling needs. This financial agreement outlines both the client's and insurance responsibilities for services rendered. Please read this agreement carefully, ask any questions you may have, and sign in the space provided.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I acknowledge that I will be required to pay a $100 fee for any missed appointment, no-show appointment, or cancellation made less than 24 hours prior to the scheduled appointment.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

Insurance

Your insurance coverage is a contract between you and the insurance company. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. It is also your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. We will submit your claims to your primary and insurance companies however we do expect payment for all services within 60 days. It may become necessary for you to pay your account in full if your insurance fails to do so within 60 days. **If we are given incorrect or incomplete insurance information you will be billed and payment will be expected within 30 days, unless the issue is resolved.**

Patient Responsibility & Payment

Payment of copays and deductibles will be due at time of service. You are ultimately responsible if your insurance denies a claim for any reason. If you do not have insurance payment in full will be due at time of service.

Payment Options

We understand that financial circumstances vary from patient to patient. We accept payment via credit card, cash, or check. Payment for services is due at the time of the appointment.

I acknowledge that I have read and understand the payment and insurance policies outlined by Thoughtful Counseling LLC. I agree to adhere to these policies as part of receiving counseling services.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

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Credit Card Authorization

I acknowledge that I have read and signed the payment policies and financial agreement form for Thoughtful Counseling LLC prior to completing the credit card authorization form

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

CARDHOLDER INFORMATION (PLEASE PRINT LEGIBLY)

Name: _____

Billing Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Phone Number: _____

CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Credit Card Number: _____

Expiration Month: _____ Expiration Year: _____

Security Code (3-4 digits on back of card): _____

I hereby authorize Thoughtful Counseling LLC to charge the above-listed credit card for any missed appointments, no-show appointments, cancellations made less than 24 hours prior to the scheduled appointment, insurance co-pays, and private payment for counseling services rendered.

Card Holder Name: _____ Relationship: _____

Card Holder Signature: _____ Date: _____