Jessica Turnoff Ferrari, LMHC, PA
4400 N. Federal Hwy. Suite 210-39
Boca Raton, FL 33431
561-445-8913
jtferrari@gmail.com

Name:_____ Date of Birth: ___/___/___

Address:_____

_____ Home Phone: _____

Other Phone: _____

(Initials) _____ I provide consent for JTF to use the contact information listed above for telephone contact and written correspondence. It is OK to leave a message on the above listed telephone number(s).

Have you previously received counseling or psychological services? □ No □ Yes

Date(s) _____ Provider(s) _____

Briefly describe your experience and outcome(s):

_____

_____

_____

_____

Primary Care Physician _____ Phone # _____

Current Medications _____

Prescribing Physician _____ Phone # _____

Emergency Contact _____ Phone # _____
Relationship to you _____

Coordination of Care

If you have multiple care-givers on your care team, it is useful to consult with your other practitioners. *I understand that my records are protected under the applicable laws governing healthcare information and cannot be disclosed without my written consent unless otherwise provided for in federal or state regulations. I also understand that I can revoke this consent at any time. This release will automatically expire when I am no longer under the care of Jessica Turnoff Ferrari.*

I_____, hereby authorize Jessica Turnoff Ferrari to release any applicable information and to discuss my care with the following physicians/ practitioners:

Name_____ Phone # _____
Name_____ Phone # _____
Name_____ Phone # _____

_____ _____ _____
Signature **Printed Name** **Date**

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Policy Information and Consent

Though you have probably seen and read documents of this nature before, please do read this as your signature on this document will indicate that you have read it, understood it, and agree to its provisions.

Confidentiality

Anything said in the context of the counseling relationship is confidential and privileged with these exceptions:

1. If a client behaves in a way that poses a threat of a physical nature to self or to another person, privilege is waived. The clinician is bound by law to contact the proper authorities as well as any other person(s) involved, and warn them of possible danger.
2. If a client is using confidentiality as a means of avoiding legal punishment, privilege is waived. That is, clinicians may not aid or abet the perpetration of a crime.
3. Court-ordered disclosures of information related to treatment may require privilege to be waived.
4. In a medical emergency privilege may be waived.
5. Mental health providers are bound by law to inform authorities of past, ongoing, threatened or suspected child abuse.
6. If you as the client or parent of the client signs a release of information form, privilege may be waived.
7. Practitioners may discuss clients without using real names for the purpose of professional development and supervision.

Appointments

Treatment sessions are 50 minutes long and are by appointment only. Brief or extended appointments can be arranged when necessary. If you find you need to cancel an appointment, the cancellation must be made 24 hours in advance. Appointments missed without 24 hours notice will be billed at the regular fee.

Training, Licensure, and Insurance

I hold an MA in Counseling Psychology from Northwestern University, and a BA from Haverford College. I have done extensive training in energy psychology and am currently licensed by the State of Florida Department of Health as a Mental Health Counselor # MH 10184.

I do not currently accept insurance. If you have mental health coverage as part of your medical insurance, you may check to see if they will reimburse you for a portion of your treatment. Full payment is expected at the time of service. If you wish to pursue your insurance company for reimbursements, this is your responsibility. I can provide a statement at the end of each month and will assist you in any way I can.

Diagnosis

If your costs are covered in part by an insurance company, coverage will require a diagnosis. Questions you have regarding your insurance company's policies on confidentiality should be addressed to the insurance company.

Medication

All decisions regarding medications must be handled by a physician or psychiatrist. Please keep me informed of any changes in medication.

I have read the above "Informed Consent for Treatment" and have clarified all questions before signing. I understand that treatment can sometimes bring painful issues to the surface. This may feel like the problems have worsened, but I understand that sometimes things appear worse before they get better. I release Jessica Turnoff Ferrari from any liability related to my/ my child's treatment, and agree to hold her and her sources of supervision harmless from any effects caused directly or indirectly from treatment. My signature below serves as my consent for treatment from Jessica Turnoff Ferrari, PA. I further agree that my therapist may discuss my case with her supervisor.

Name _____ Signature _____

Date _____