Abba's Heart Counseling Center, Inc.

Terms of Confidentiality, Business Practices, and Release of Liability

Abba's Heart Counseling Center, Inc. (hereafter, AHCC, Inc.) is operated to provide counseling services with a client and Christ centered focus to members of the community. Counseling is provided by a Christian practitioner who has earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who has been licensed by the State of Florida as a Mental Health Counselor (hereafter referred to as Counselor). Counseling can also be provided by a registered intern, who has earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and is registered with the State of Florida, or by a graduate intern, who is currently attending an accredited graduate program.

The completion of an intake questionnaire and an informed consent and release of liability are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent. In order to initiate counseling, please read the following agreement. Your signature attests that you both understand and agree to the terms and conditions contained herein.

I _____understand that my counselor is a Licensed Mental Health Counselor, working under the laws and rules specified by the state of Florida and/or the Federal Government where applicable. I also understand and give my consent that:

COUNSELING: Counseling is a collaborative process between you and a counselor to work on areas of dissatisfaction in your life and assist with life goals. For counseling to be most effective, it is important that you take an active role in the process. Counseling practices are governed by The Florida Board of Clinical Social Work, Marriage & Family Therapy, and Mental Health Counseling and counseling services will fall within the legal and ethical guidelines set forth by the governing board. I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress.

CONFIDENTIALITY: As a Licensed Mental Health Counselor in the State of Florida, I am bound by Florida State Statue 491.0147 to maintain any communications as confidential. I understand that my counseling records (files) are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession (e.g. child, elder, disabled abuse/neglect reporting requirements, serious threat of harm to self or others, etc.) The clinical records are the property of AHCC, Inc. and as such, are deemed records of confidential sessions between counselors and clients. Other than as required by law these records will only be released subject to the following paragraph and with the advanced written consent of the client and AHCC, Inc. I hereby release my files and records to all volunteer interns or staff of AHCC, Inc. for the sole purpose of billing insurance and to maintain accounting records.

RISKS: In counseling, major life decisions are sometimes made, including decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. These decisions are a legitimate outcome of the counseling experience as a result of a individual's calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be too intense too deal with at this time. I will be available to discuss any of your assumptions or possible negative side effects in our work together.

ELECTRONIC TRANSMISSION: I cannot ensure the confidentiality of any form of communication through electronic media (i.e. phone calls, text messages, Skype sessions, phone conferences, emails, etc). The upmost care and concern will be performed at AHCC to maintain confidentiality in regards to electronic transmissions, but by signing this agreement, you acknowledge and understand, and hold harmless of any and all liability to AHCC, Inc. on any breach in confidentiality due to electronic transmission communications.

TIME PARAMETERS: Individual appointments for self-pay clients are scheduled for 50-minute sessions. Individual appointments for insurance clients are scheduled for 45-minute sessions under billing code 90834, or 60-minute sessions under billing code 90837. Being late for an appointment by 20 minutes or more, may require you to pay for the missed appointment and reschedule the session.

INSURANCE: If you are an insurance client, you understand and waive your right to confidentiality in order for us to file insurance on your behalf. In order to do so, I have to assign you a diagnosis. If you have any questions about this, please let me know. I will certainly share any information with you that I provide to an insurance provider. At the time of service, you will be responsible for paying either your copay or deductible. If the insurance claim is denied, you understand and agree to pay all counseling fees in full. I will only file insurance on your behalf if I am an approved provided for the specified insurance company. If I am not an approved provider, fees will be paid in full at the time of service and I will happily give you a super bill and you will be responsible for submitting the claim to your designated insurance company for reimbursement.

CONSULTATION: Information about you may be discussed in confidence, without revealing your identity or any identifying information, with other counseling, medical, legal, or business professionals (when deemed applicable) for the purpose of consultation and providing you the best possible service.

FEES AND PAYMENTS: All copays, deductibles, and fees will be collected at the time of service or charged to your credit card as necessary, if you consented to keep your credit card on file.

CANCELLATIONS: If you find it necessary to cancel an appointment, please contact me at 407-285-6284 at least 24 hours in advance. Email communication will not be accepted as a form of cancellation**. Cancellations with less than a 24-hour notice will be a charged a $125.00 no-show fee.** If you are an insurance client, please know that insurance cannot be billed if you fail to give adequate cancellation notice. You will be charged the full agreed upon insurance rate if there is less than a 24-hour cancellation notice.

SCHEDULING: I understand that all communications about appointments and scheduling will be made directly with my counselor, Angie S. Mabe. However, I also understand that life emergencies and illnesses happen and in the event that my counselor, Angie S. Mabe has a life emergency or illness, I agree to allow her colleague Renata Cerveira, LMHC or spouse, Joseph Mabe, access to my contact information in order to handle any scheduling conflicts.

RELEASE OF LIABILITY: In consideration of the benefits to be derived from the counseling, the receipt of which is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable the business or ministry of Abba's Heart Counseling Center, Inc., the licensed Counselors, registered interns, graduate interns, volunteer interns, all billing and accounting staff, and the supervisors, if applicable, from any and all claims, demands, damages, actions, or causes of action whatsoever related to the counseling process. I waive any right I may have otherwise have to seek to use my counseling records with Abba's Heart Counseling Center, Inc., except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any Counselor or supervisor associated herewith. If testimony is required, I agree to pay twice the normal hourly rate for any, and all, of these individuals for their testimony, and preparation therefore.

I have read and understood the preceding information and agree to the terms and conditions set forth by Abba's Heart Counseling Center, Inc. and agree to the terms and conditions stated herein. I understand that these comments are prerequisites to my receiving and continuing counseling services through AHCC, Inc.

_____ _____ _____

Client Name Signature (Legal Guardian or Parent) Date