WELCOME TO THE OFFICE OF KAREN WOOD, LMHC

Our address is 2400 North University Drive, Suite 201, Pembroke Pines, FL 33024 (we are located on the southwest corner of University Drive and Sheridan Street in the Capriccio Plazayou will see an electrical substation on that corner) at the west end of the plaza. Please enter through the door addressed "Elevators to 2nd Floor". This entrance is located between the dental office and the pediatrician's office. Please do not GPS our location as you may be directed to an incorrect address. If you are lost or running late please contact Karen Wood directly at 954-536-5266, as you will not be able to reach me at the number below at all times.

You will receive under separate email, confirmation of appointment with Ms. Wood via text and email through our online calendar Counsol. You will also receive a welcome email with a link; please take a moment to sign into the Secure Client Area within 24 hours enabling you to schedule your own future appointments, cancel appointments, etc. Initially, your username will be your email address and a temporary password will be provided. Once you are logged in you can change your username and password to your liking. After 24 hours, your link will expire.

PRIOR TO YOUR FIRST APPOINTMENT, PLEASE PRINT AND COMPLETE ALL INTAKE FORMS AND BRING WITH YOU TO YOUR APPOINTMENT (FORMS ATTACHED TO THIS EMAIL). IF YOU ARE UNABLE TO BRING THE COMPLETED FORMS WITH YOU, PLEASE SHOW UP TO YOUR APPOINTMENT 10-15 MINUTES EARLY TO COMPLETE THEM. KEEP IN MIND SESSIONS ARE 45-50 MINUTES IN LENGTH AND WE DO NOT WANT TO TAKE TIME AWAY FROM YOUR SESSION FOR FILLING OUT PAPERWORK/PAYMENT. ALSO, PLEASE HAVE YOUR CO-PAY OR PAYMENT IF ANY READY PRIOR TO THE SESSION AS WE DO COLLECT PAYMENT PRIOR TO THE SESSION. AGAIN, WE EWANT YOU TO HAVE YOUR FULL SESSION TIME.

I accept payment preferably via these phone apps:

ZELLE at 9545365266

VENMO at karenrowland99

Check to Karen Rowland or cash. **Like a doctor's office, please pay PRIOR to your session to avoid losing time from your actual session time**.

If you are ever running late, please call or text Karen at 954-536-5266. After 15 minutes, if there is no show and no notification, Karen will assume that you are not coming and you will be subject to a cancellation fee.

Thank you,

The office of Karen Wood, LMHC, CAP 954-529-0885 OFFICE 954-536-5266 KAREN'S CELL
www.browardcounseling.com admin@browardcounseling.com

PLEASE SIGN AND DATE BELOW TO ACKNOWLEDGE RECEIPT OF THIS IMPORTANT INFORMATION

Prior to your first appointment, please print out and complete all intake forms and bring with you to your appointment. If you are unable to bring the completed forms with you, please show up to your appointment 15 minutes early to complete the paperwork prior to your session.

PLEASE KEEP IN MIND THAT WE ARE A FORM OF MEDICAL OFFICE AND THEREFORE OPERATE IN THE SAME FASHION:

Remember to bring your co-pay, coinsurance amount, or self pay fee all of which are due at the beginning of your appointment. Please have your payment ready prior to your appointment as we want you to have your full allotted amount of time with your therapist, otherwise a portion of that time often is used for paying your fee for services. We accept check, cash or if using a credit card a 4% convenience fee will be charged. We also now accept payment through the Zelle and Venmo Apps. If you are using the Zelle App for payments you will need to add Karen Wood, LMHC to your contacts list (954) 536-5266 the Venmo account name is @KarenRowland99. Please indicate the patient's name in the App prior to processing the payment. PARENTS MAY NOT DROP OFF MINORS WITHOUT PREVIOUS DISCUSSION WITH THE THERAPIST. If it is agreed that an underaged client will be sent without a supervising adult the session must be PREPAID. Failure to do so will result in cancellation of the session, and a fee of $75 will be charged. Please remember that we have our office manager at 954-529-0885 to assist you with these issues.

Please also keep in mind that, like other medical offices, we may not always run exactly on time. Due to the nature of our office, we oftentimes have clients in crisis. These moments may require a few extra minutes. If you ever require those few extra minutes, you will be provided the same. Thank you for your patience.

We strongly encourage you to familiarize yourself with our online calendar CounSol; our online calendar allows you to make and cancel appointments at your leisure.

Please inform us 24 hours prior to your appointment if you need to cancel/reschedule your appointment; if your scheduled for a 4:30 pm appointment, the cancel/reschedule policy is 48 hours prior to your appointment to avoid the late/no cancel fee of $75.00 as noted in our financial policy by either going on the Counsol appointment app of calling the office manager at 954-529-0885. Karen Wood, LMHC does NOT manage the appointments, so please do not call her or tell her to cancel or change your appointment. Doing so without doing one of the above will result in a cancellation fee. New clients are required to pay a $30.00 fee at the time an appointment is made; this amount is reimbursable; however if you do not show to the appointment or the appointment is not cancelled per our cancellation policy, the $30.00 fee will not be reimbursed.

_____ _____

Print Name Date

_____

Signature

***PROVIDE COPY TO CLIENT**

PLEASE COMPLETE WHICHEVER CHECKLIST APPLIES.
IF THE CLIENT IS BETWEEN THE AGES OF 14 AND 17, PLEASE COMPLETE BOTH.

Adult Checklist of Concerns

Name:_____ Date: _____

Please mark all of the items below that apply and feel free to add any others at the bottom. You may add a note or details in the space next to the concerns checked.

- o Abuse (please specify)
- o Aggression, violence
- o Alcohol use
- o Anger, hostility, arguing, irritability
- o Anxiety, nervousness
- o Attention, concentration, distractibility
- o Career concerns, goals and choices
- o Childhood issues (your own childhood)
- o Children, child management, child care, parenting
- o Codependence
- o Confusion
- o Compulsions
- o Custody of children
- o Decision making, indecision, mixed feelings, putting off decisions
- o Delusions (false ideas)
- o Dependence
- o Depression, low mood, sadness, crying
- o Divorce, separation
- o Drug use
- o Eating problems
- o Emptiness
- o Failure
- o Fatigue, tiredness, low energy
- o Fears, phobias
- o Financial or money troubles, debt, impulsive spending, low income
- o Friendships
- o Gambling
- o Grieving, mourning, deaths, losses, divorce
- o Guilt
- o Headaches, other kinds of pain
- o Health, illness, medical concerns
- o Inferiority feelings
- o Interpersonal conflicts
- o Impulsiveness, loss of control, outbursts
- o Irresponsibility

- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions
- Oversensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination
- Relationship problems
- School problems
- Self centeredness
- Self Esteem
- Self neglect, poor self care
- Sexual issues
- Shyness, oversensitivity to criticism
- Sleep problems, too much, too little, nightmares
- Smoking/ tobacco use
- Stress, relaxation, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolation
- Work problems, employment, overworking, can't keep job

Other concerns or issues:_____

_____

_____

Child Checklist of Characteristics

Name:_____ Date: _____

Age:_____ Person completing this form: _____

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first, please mark all of the items that apply to your child on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- ○ Affectionate
- ○ Argues, "talks back," smart-alecky, defiant
- ○ Bullies/intimates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ○ Cheats
- ○ Cruel to animals
- ○ Concern for others
- ○ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- ○ Complains
- ○ Cries easily, feelings are easily hurt
- ○ Dawdles, procrastinates, wastes time
- ○ Difficulties with parent's paramour/new marriage/new family
- ○ Dependent, immature
- ○ Developmental delays
- ○ Disrupts family activities
- ○ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ○ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ○ Dropping out of school
- ○ Drug or alcohol use
- ○ Eating-poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ○ Exercise problems
- ○ Extracurricular activities interfere with academics
- ○ Failure in school
- ○ Fearful
- ○ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ○ Fire setting
- ○ Friendly, outgoing, social
- ○ Hypochondriac, always complains of feeling sick
- ○ Immature, "clowns around," has only younger playmates
- ○ Imaginary playmates, fantasy
- ○ Independent
- ○ Interrupts, talks out, yells
- ○ Lacks organization, unprepared
- ○ Lacks respect for authority, insults, dares, provokes, manipulates
- ○ Learning disability
- ○ Legal difficulties-truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ○ Likes to be alone, withdraws, isolates
- ○ Lying
- ○ Low frustration tolerance, irritability
- ○ Mental retardation

- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor-competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors-biting or hitting self, head banging, scratching self
- Speech difficulties
- Sexual-sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, blasphemes, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics-involuntary rapid movements, noises, or word productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Underactive, slow-moving or slow-responding, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

- _____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it?_____

Karen Wood, LMHC, CAP
CONSENT FOR SERVICES

As a client of Karen Wood, LMHC, CAP we are obligated to inform you of your rights to confidentiality.

I understand that I am ensured the following rights:

- The right to refuse and /or terminate treatment at any time.
- The right to a complete description and explanation of my counseling.
- The right to confidentiality, whereby, information revealed by me during individual or group therapy , evaluation or testing will be kept STRICTLY CONFIDENTIAL and will not be revealed to anyone without my written authorization. The law provides exceptions to this provision:

1. If the therapist has knowledge of the clients' intent to harm himself or others (homicide/suicide with a plan).
2. If the therapist receives a court order to the contrary.
3. If the therapist has knowledge of neglect/abuse to children or elderly.

Due to grey areas of duty to warn regarding HIV issues, our counselors have chosen to adopt the policy of working with the client regarding these grey area issues. This policy will reduce the risk of jeopardizing the therapeutic relationship and also protect the liability of the therapist to the greatest extent possible regarding invasion of privacy, defamation, or breach of confidentiality. These issues include but are not limited to:

1. If, in my opinion, therapy cannot profitably proceed unless something you tell me is shared with another party. I may need to give you the choice of telling the other party yourself, having me tell them, or terminating therapy.

2. I have an ethical obligation to balance the interests of all human beings. If you tell me, in my opinion, of a situation that may be unethical, harmful, or unfair, I may, at my discretion, give you the choice of correcting the situation if possible, informing relevant party(ies) of the situation, having me tell them, or terminating therapy.

3. In general, I will follow, to the best of my ability, all state laws and regulations, as well as the policy and code of ethics of the Florida Department of Professional Regulation.

4. Please feel free to ask for clarification about any of these matters at any time, either now, during therapy, or before you tell me something I might have to share with others.

Please note that payments are due upon receiving services. We require a 24-hour notice of cancellation of appointments. We have a 48-hour notice of cancellation policy if you have a 4:30 pm due to the high demant of this appointment time. Our missed appointment fee is seventy-five ($75.00) dollars for insurance clients and $150 for court clients. Repeated cancellation of appointments and/or failure to comply with treatment recommendations is counterproductive and may result in termination of your treatment with the option of referral to another treatment source.

5. Checks returned for insufficient funds will be subject to a fee of thirty five dollar ($35.00) administration fee above and beyond the bank's penalty fee. If such an event occurs more than __

6. Sessions are an average of 45 to 50 minutes in length. Insurance companies only pay for 45 minutes.

7. If you are finding it difficult to wait until your next session to speak to your therapist you will need to schedule appointments more than once per week. Phone sessions can be arranged through the office manager and are available on some mornings and weekends.

8. Emails and texts are also billable and not covered by insurance.

9. In case of an emergency at a time when your therapist is out of town call 911 or First Call For Help at 954-467-6333.

10. **Legal proceedings, Reunification, Extended Co-Parenting or Parenting Coordination will be charged for all phone calls, emails, texts, report writing/review at a rate of one hundred and fifty dollars ($150.00) per hour and court appearances/depositions door to door at a rate of two hundred dollars per hour ($200) charged at one-tenth of an hour including preparation time and travel. These services are NOT covered by your insurance plan. IF YOU BECOME INVOLVED IN A FAMILY COURT CASE AT ANY TIME DURING YOUR TREATMENT, YOU MAY BE SUBJECT TO THIS GUIDELINE.. WE DO NOT ASSIST IN DISABILITY FILINGS.**

11. **Please be advised that all court involved cases require a retainer of $1,000.00 per parent or $2000 if being paid by one parent. Retainers may be paid by check, cash or credit card. Please note if you choose to use a credit card a fee of 4% will be charged to you in addition to the $2,000.00 retainer. At the end of the treatment any retainer balance will be returned to the client. Retainer amounts must be kept at a minimum of $300.00. If your retainer balance falls below $300.00 and it is 48 hours prior to your next scheduled session, that session will be cancelled until the retainer amount is replenished to $1,000.00; replenishing your retainer is necessary regardless of the clients' intent to pay cash or check for that session. The client will be provided with an itemized statement monthly or at the time your retainer falls below $300.00. At this time the client will be required to replenish their retainer to $1,000.00. All services will be suspended until the retainer is replenished.**

12. **All clients involved in parent/child reunification counseling must respect the process by following all recommendations of the therapist. The non-participating parent may not be present in the waiting room during the time of the reunification session and may not attend these sessions unless it is requested by the therapist. Any information non-participating parent feels it is necessary to share will occur via a separate appointment. This time is not billable by your insurance company.**

13. **Please be sure to inform me of any custody arrangements or legal guardianship issues that I should be aware of pertaining to any minor that is brought in for treatment. Written consent is required by both parents in order for me to provide any counseling to a minor.**

I hereby certify that I understand the above and have been informed of service policies and procedures. Furthermore, I authorize Karen Wood, LMHC, CAP to render necessary treatment and to file appropriate insurance claims for this treatment if necessary. If I do not have insurance, I agree to pay for services as they are rendered.

Name _____ Date _____

Karen Wood, LMHC, CAP

FINANCIAL AGREEMENT

Name: _____
Cardholder Name: _____
Credit Card Type: _____ Credit Card Number _____
Expiration Date: _____ Security Code: _____
Credit Card Billing Address: _____
City: _____ State : _____ Zip Code: _____
I agree to allow Karen Wood, LMHC to charge payments due at the time of services, fees and invoice balances to my credit card. I have read and understand Karen Wood, LMHC's fee agreement, fees for services and cancellation policy.

_____ _____
Cardholder/Patient Signature Date

Charges may include:

_____(initials) Self pay non-court related clients **$125.00** per session; court related clients **$150.00** per session; court appearance/deposition related services including preparation, travel and court appearance **$200.00** per hour.

_____(initials) Phone sessions, emails, texts and emergency phone calls can also be charged to my insurance (if appropriate) or authorized credit card (plus 4% charge) at the rate of **$125.00** per hour for non-court related clients and **$150.00** per hour for court related clients.

_____(initials) Charge for cancellation without 24 hours' notice or 48 hours' for 4:30 appointments for a no-show appointment: non-court related clients **$75.00** as agreed in the Policies and Procedures; court related clients **$150.00** as agreed in the Policies and Procedures.

_____(initials) I agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, which will be charged for any outstanding balance owed.

_____(initials) Outstanding balances beyond 30 days are subject to a **$20.00** administrative fee being added to your account balance EVERY 30 DAYS due to administrative costs. Outstanding balances beyond 60 days are subject to your account being forwarded to an outside collection agency.

_____(initials) Returned checks will be subject to an additional fee of **$35.00** in addition to any bank fees which must be paid within 30 days and must be paid by cash or money order to Karen Wood, LMHC.

_____(initials) I agree to not dispute any charges and understand that if I do so I will be responsible not only for the charges for services rendered but any charges accrued by the credit card company or collections agency. All invoices are charged based on records kept on file and are allowed to be released to all parties in the case of a dispute.

_____ (initials) I understand that no child under 18 can be dropped off without a parent or guardian and if it is agreed that the child is permitted to be left, session must be prepaid.

_____(initials) There is no receptionist and I understand I will need to wait in the waiting area until greeted by Karen. Please do not knock on the door.

_____(initials) I understand that if I come to my session sick, I will not receive my session and will be charged a $75 fee. Cancel us, stay home and get well.

Signature: _____ Date:_____

KAREN WOOD, LMHC FINANCIAL POLICY

I consent to psychological therapy, consultation and/or testing. I understand that it is my responsibility to cooperate with treatment. Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. **I understand that if I do not agree with this policy I have the option to pay cash for services to protect my privacy.**

Signature: _____ Date: _____

Signature: _____ Date: _____
(Second parent)

I authorize payment of medical benefits to Karen Wood, LMHC for services rendered. If a problem occurs with the insurance company regarding payment of medical benefits, the patient is responsible for payment of the medical benefits for services rendered in our office. All follow-ups with the insurance company are the responsibility of the patient.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Charges for services are due and payable at the time services are rendered, unless prior arrangements have been made with your therapist. If you have health insurance, it should be understood that this is an arrangement between you and your insurance company to pay you certain amounts for medical care. Your therapist's bill is an agreement between you and your therapist. You are responsible for payment of your bill, regardless of the status of your insurance claim. Insurance companies have a schedule of fees, which they will pay. If you fail to meet your financial responsibilities, your account may be turned over to a collection agency or the appropriate court. You will be responsible for a $20 administration fee per month for every month that our office attempts to collect on any amount owed. I hereby give my consent to release necessary information for taking such action. The patient will be responsible for any fees incurred because of collection or court actions.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Because time has been reserved exclusively for me and/or family member(s), I understand that I am required to provide at least twenty-four (24) hours advance notice or forty-eight (48) hours for a scheduled 4:30 pm appointment if unable to keep the scheduled appointment. **In the event that I do not provide the twenty-four (24) hour notice or forty-eight (48) hour notice for 4:30 pm appointments, I am responsible for the reserved appointment at the rate of seventy-five ($75.00) dollars for non-court related clients and one hundred and fifty ($150.00) dollars for court clients.**

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)