VICTORIA EHMEN, MA LMFT ACST
420 NORTH HALIFAX AVENUE SUITE 130
DAYTONA BEACH, FL 32118

You have the right to look at the health information I have about you such as your medical or billing records. You can obtain a copy of these records, however, there may be a charge for copies of these records.

Please Return Prior to First Session
-Copy of your Driver's License or Photo ID
-New Patient Intake Form
-Notice of Privacy Practices (NPP) and HIPAA Patient Rights, signed and dated
-Informed consent for online therapy and electronic communications.

Signature_____ Date_____

Thank you,
Victoria Ehmen, MA LMFT
daytonabeachsextherapist@gmail.com

(386) 866-1949

VICTORIA EHMEN, MA LMFT ACST
420 NORTH HALIFAX AVENUE SUITE 130
DAYTONA BEACH, FL 32118

Patient Intake Form

Patient's Name_____

Address_____

City, State and Zip_____

Phone _____Mobile _____

Email Address _____

Alt. Email Address _____

Occupation/Employer_____

Date of Birth (DOB) _____Age_____

Marital Status_____ Spouse's Name_____ Date of Birth _____

List Members of your household _____

Educational Background_____

Briefly describe your reason for seeking help:

Referred by: ____Doctor ____Internet ___Friend/Other

Physician's Name_____ Phone_____

When were you last seen by a physician? _____

List any major health problems for which you are currently receiving treatment

VICTORIA EHMEN, MA LMFT ACST
420 NORTH HALIFAX AVENUE SUITE 130
DAYTONA BEACH, FL 32118

List any medications you are currently taking:

Have you ever received, psychiatric, psychological, or counseling in the past? If yes, please explain.

Who is financially responsible for the cost of counseling?

How will you be paying for services?

_____Check _____PayPal

Please include a copy of your driver's license or photo ID.

If you have any questions, please call Victoria Ehmen at
(386) 866-1949 or davtonabeachsextherapist@gmail.com

I request 24 hrs cancellation notice for non-emergencies.
No shows and late non-emergency cancels are billed at my full rate.

VICTORIA EHMEN, MA LMFT ACST
420 NORTH HALIFAX AVENUE SUITE 130
DAYTONA BEACH, FL 32118

Notice of Privacy Practices (NPP)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully,

My commitment to your privacy. My practice is dedicated to maintaining the privacy of your personal health information. I am also required by the HIPPA law of 1996 to do this. These laws are complicated, but I must provide you with some important information. This is a condensed version of the full, legally required NPP which is available for your review. I cannot cover all possible situations, so please ask if you have any questions or problems. I will only use the information about your health which I obtain from you or from others mainly to provide you with treatment, to arrange payment for my services, or for some other business activities which called in the law, health care operations.

If you or I want to use or disclose your information for any other purpose, we will discuss this and you will be asked to sign an authorization (Release of Information form) to allow me to send, share, or release your information with a third party.

I will keep your health information private, but there are times when the law requires me to use or share it, such as:

- When there is a serious threat to your health or safety or that of another individual or the public. I will only share information with a person or organization who is able to prevent or reduce the threat.
- When there is a disclosure of abuse of a child or of the elderly. Some lawsuits, legal, or court proceedings.
- If a law enforcement official requires me to do so.

There are other situations similar to these, which are described in the longer version of the NPP.

Your rights regarding your health information.

You may ask me to communicate with you about your health and related issues in a certain way or place. For example, you can request calls only at home, not at work, to schedule or cancel an appointment. I will try my best to accommodate your request. You have the right to ask us to limit what I tell certain Individuals involved in your care, or the payment of your care, such as a family member or friend. While I do not have to agree to your request, If I do, I will keep our agreement, except If it against the law, or in an emergency, or if the information is necessary to treat you.

Signature_____ Date_____

(If minor, Your Printed Name) _____

Relationship to Minor_____

Address_____

VICTORIA EHMEN, MA LMFT ACST
420 NORTH HALIFAX AVENUE SUITE 130
DAYTONA BEACH, FL 32118

Informed Consent for Online Therapy and Electronic Communication
Prior to starting video-conferencing services, you understand and agree to the following limitations of using telehealth for online therapy:

I understand there are risks inherent in the electronic transmission of Information by email, text messages or the internet. There are potential benefits and risks to video-conferencing (ag. Limits to patient confidentiality) that differ from in-person sessions.

Confidentiality still apples for telehealth services and nobody will record the sessions without the permission of another person(s).

It is Important to be in a quiet, private place that is free of distractions during the session. It is Important to use a secure internet connection rather than a public/free Wi-Fi.

l agree that Victoria Ehmen may communication with me electronically by text, email, phone and video conferencing unless and until I revoke this authorization. I request 24 hrs notice of cancellation. Non-emergency late cancels and no shows are billed at full rate.

Patient's Printed Name_____

Signature _____

(If minor) Your Printed Name_____

Relationship to Minor_____

Phone _____

Date _____

VICTORIA EHMEN, MA LMFT ACST
420 NORTH HALIFAX AVENUE SUITE 130
DAYTONA BEACH, FL 32118

Authorization to Disclose Protected Health Information

Patient's Name_____ Date of Birth_____

Address_____

hereby authorize _____to disclose the following information:

___Progress or case notes diagnosis
___Psychological, psychiatric, diagnoses,
___Prognosis, Treatment notes, recommendations
___Testing record, or Behavioral Observations by any staff member
___Drug and alcohol information
___Admission and/or discharge summaries
___Billing Information
___Medication log or pertinent information
___Inpatient/outpatient treatment records
___Treatment Summary
___Summary of contacts

Dates of care from _____to_____ to this person_____

Address_____

The information disclosed is for the purpose of _____

Date of Authorization _____

I understand that after this date or event, no additional information shall be used or released.

This Authorization may be revoked, in writing, at any time unless said information has already been released. I understand that I do not have to sign this release and that it will not affect my treatment. I further understand that the potential exists for re-disclosure of my protected health information and that it may no longer be protected under HIPAA privacy regulations. In certain circumstances, such as matters of danger to myself or others, abuse or neglect of the elderly or children, this information may be disclosed without my written permission.

This is to clarify that I have given consent freely and voluntarily and that this release has been explained to me. I have received a copy of this release. Y_____N_____

Signature (client or personal representative)_____Date_____

Federal Regulation prohibits the recipient from making any further disclosures of this information.