Megan Linden-Haataja, LCSW, LMFT, PA
1412 Royal Palm Square. Suite 103
Ft. Myers, FL 33919
239-936-8281
email: Meganhaataja@embarqmail.com
Web: www.fortmyersfamilycounseling.com

Welcome to our office. If you will fill out the registration forms, we will get to know you and if you read the following you will learn about the office.

Megan Linden-Haataja LCSW PA is a Licensed Marriage and Family Therapist and a Licensed Clinical Social Worker in the State of Florida. Mrs. Haataja has her Bachelor's Degree in Psychology from Florida State University and her Master's Degree in Clinical Social work with a focus in children and families from Barry University in Miami. Mrs. Haataja specializes in individual, child and adolescent therapy, and family therapy. Mrs. Haataja treats a range of issues including depression, anxiety, ADHD, medical trauma, behavioral disorder, grief work, abuse and stress management. Mrs. Haataja has weekly groups and uses multiple therapeutic modalities not limited to brief therapy, crisis intervention, cognitive behavioral therapy and employee assistance.

Your Initial Evaluation:
On your first visit we will ask you to complete registration forms for our office records, At that time you may also be asked to fill out an authorization form for a release of information to and from doctors, hospitals, insurance companies, etc.

Future Appointments:
We request that you be prompt for appointments. If you find it necessary to reschedule or cancel your appointment we required at least two working days notice prior to the appointment time or the usual fee will be charged.

Telephone Calls;
If you find it necessary to contact the office during the week please speak with the Office Manager or leave a message on the voice mail. If you need to set up a telephone consultation with Mrs. Haataja, please leave your name and number and she will return your call. A fee for a telephone consultation will be charged.

Accounts/Payable:
All accounts are the responsibility of the patient and are payable directly to Mrs. Haataja. Megan Linden-Haataja DOES NOT become involved in and insurance companies do not cover claims that are related to accident and other types of litigation matters, If your insurance company has referred you to the office you must have an authorization number or payment is due in full. If you are authorized to see Mrs. Haataja, all co-payments are payable at the time of service. Cash or Checks ONLY.

Office Hours:
The office is open Monday-Friday from 9am-5pm. Later/evening appointments are based on availability and priority only.

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Notice of Psychotherapist's Policy and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOTHERAPEUTIC AND MEDICAL INFORMATIONABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations.

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  _ Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
  _Payment is when I obtain reimbursement for your healthcare. Examples of payment are when disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
  _Health Care Operations are activities that relate to the performance and operations of my practice. Examples of health care operations are quality assessment and improvement activities,business-related matters such as audits and administrative services, case management and care coordination.
- "Use" applies only to activities within my (office, clinic, practice group, etc)such as sharing, employing, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my (office, clinic, practice group, etc)such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization.

I may use or disclose PHI for purposes outside if treatment, payment and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "psychotherapy notes: are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosure with Neither Consent nor Authorization.

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disable or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Marriage and Family Therapy, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

IV. Patients Rights and Psychotherapist's Duties.

Patient's Rights:

Right to Request Restrictions- You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means at Alternative Locations- You have the right to request and received confidential communications of PHI by alternative means and at alternative locations. (For examples, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.

Right to Amend- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to Accounting- You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy- You have the right to obtain a paper copy of the notice from me upon request.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI an to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a written notice of such revision (s) by mail.

V. Complaints.

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact The Board of Marriage and Family Therapy for further information.

You may also send a written complaint to The Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restriction and Changes to Privacy Policy.

This notice will go into effect on April 14, 2013

I will limit the uses or disclosures that I will make as follows: Some PHI and psychotherapy notes may not be released to the patient or to other parties if such release is judged to be clinically inadvisable or potentially harmful to the patient. In such cases, a written summary of the requested information will be provided, as allowed in the Florida State statutes. Raw test data will not be released to the patient or other parties with the following exceptions: 1) There is a court order to release raw test data specifically, or 2) There is a patient authorization to release raw test data directly to a Psychotherapist qualified to review the specific type of test data requested. All other limitations on uses or disclosures will be discussed with the individual patient concerned.

I reserve the right to change the terms of this notice and to make the new provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

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Name_____ Birthdate_____

Street Address_____

City_____ State_____ ZipCode_____

Telephone_____ Cell Phone_____

Who does child reside with?_____

Parent(s)/Legal Guardian(s) name_____

Are you involved in any type of legal proceedings or law suits that may involve any of your counseling here? **Y** **N** If yes please explain_____

_____

Family History of: Mental Disorder Physical/Sexual Abuse Substance Disorder
Suicide/Homicide: If any are circled please explain:_____

_____

School Name_____

Clients Medical Doctor_____

Are you taking any medications? If so, Please list_____

Name of referring physician or person_____

Good Health_____ Have you been to counseling before?_____

Check of any the following that applies: Depression_____ Anxiety_____ Sleep Disturbance_____

Difficulty Relaxing_____ Cries Easily_____ Anger_____ Behavioral Issues_____

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Consent for Counseling

Name_____

Address_____

Social Security Number_____

In case of emergency who should we contact? Please list name and number

_____

I, the undersigned, voluntarily agree to participate in counseling services, I understand that any information obtained will be held in the strictest of confidence with the exception of legal requirements for disclosing information. I further understand that I can authorize the release of information by completing a written consent form.

I recognize that I have the right to withdraw from therapy at any time, without prejudice, which would void this consent for counseling. I understand that I will be given the opportunity to ask questions about the foregoing to my satisfaction. I have also been provided with a copy of the office policies and agree to abide by them.

_____ _____
Client's Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
Witness Signature Date

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physician is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

I, _____, _____ _____, for the purpose of coordinating care, authorize
(Patient Name-Print) (D.O.B) (Social Security No.)
_____, to release information indicated in the "Consent" portion of this form to:
(Provider Name-Print)

PCP Name:_____**PCP Phone** _____

PCP Address: _____
(Street) (City) (State) (Zip)

Information For PCP:

The patient was seen by me on (date): _____ for (Diagnosis):_____

Treatment Plan:_____

For Psychiatrists Only:
The following medications(s) was/will be started: (list medications and dosage)_____
_____

____Medication was not indicated _____Patient Refused medication ___ Psychotherapy suggested before trying med.
____I recommend the following medical intervention by PCP before initiating medications:
Medical work-up for:_____

Lab tests for: ____CBC ____Thyroid Studies ____Chem Panel ___EKG
Other:_____

Please call me at ( ) _____, to discuss this case further or if you need any other information.

_____
(Provider Signature) (Provider Printed Name) (Licensure)

CONSENT

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my consent:
Patient please check one:

( ) To release any applicable mental health/substance abuse information to my primary care physician
( ) To release <u>only</u> medication information to my primary care physician.
( ) I <u>do not</u> give my consent to releasing any information to my primary care physician.

_____ _____
Patient Signature (Patients over 18) (Date) Parent/Guardian Signature (Patients under 18) (Date)

_____
Witness (Date)

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Patient's Name:_____

Name of Responsible Party:_____

Billing Address:_____

Primary Therapist: Megan Linden- Haataja, LCSW PA

Fee per visit: $150.00

Cancellation Policy: 48 hour or two working days notice in advance or the above fee will be charged

Special Pay Arrangements:_____

_____

I understand that any portion of the account balance over 90 days old will be subject to a finance charge of 2% per month (or 18% annually). I also understand that a request for a duplicate monthly statement will be charged at $5.00 per statement.

I hereby authorize Megan Linden-Haataja to release information concerning my treatment to my insurance carrier in accordance with the code of the State of Florida.

I hereby acknowledge responsibility for this account and guarantee payment of all charges against this account. I understand that this account is my responsibility and not that of my insurance company.

In the event it is necessary for Megan Linden-Haataja, LCSW to secure a third party to collect on my past due account, all fees and expenses for this service shall be borne by me. In the event that this should become necessary for Megan Linden- Haataja, LCSW to collect my bill in this manner, I relinquish my right to privacy concerning my treatment here.

_____

Signature of Responsible Party Date

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Name:_____ Date of Birth:_____

Insurance Company:_____HMO_____PPO_____POS_____

Authorization number(if necessary):_____

Primary Care Physician:_____

Are you currently being seen by a psychiatrist?_____

Name of Psychiatrist:_____

Prescribed Medications(s)_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

Have you ever been hospitalized for a mental condition?_____If so, how many times?_____

Please list dates of hospitalization_____

Have you ever had a substance abuse problem?_____

Do you currently have a substance abuse problem?_____

Reason for counseling?_____

I authorize Megan Linden- Haataja, LCSW PA to leave a message on (Please check all that apply):

Home answering machine_____Cellphone_____Employment_____None of the above_____

I authorize Megan Linden- Haataja, LCSW PA office to release medical information to my insurance company. I am also authorizing benefits to be paid directly to Megan Linden-Haataja, LCW PA.

_____ _____

Client Signature Date

General Information Form

1. What problem has brought you to counseling?

   _____

2. Why have you decided to get counseling now to deal with this problem_____
3. Have you ever been in counseling before?_____ If so, when_____
   _____Location of treatment_____
   Type of counseling (family, individual)_____
   What was the response to the treatment?_____
4. Do you have any thoughts of hurting yourself or anyone else? If yes, please explain._____

   _____

5. Please list any relevant family history._____

   _____

6. Please list any psychiatric, counseling or medical lab results._____

   _____

7. Please list any emotional or medical misc. Consultation received._____

   _____

Previous Treatment inpatient alternative outpatient detox self-help

Substance related disorder

Last 6 mos. _____ _____ _____ _____ _____

Lifetime _____ _____ _____ _____ _____

Mental heath care

Last 6 mos. _____ _____ _____ _____ _____

Lifetime _____ _____ _____ _____ _____

Medical/medication History

check if none in the pat 90 days_____

Medication	Dose	Frequency	Prescribing Clinician

Any reaction to the medication? _____

Do you have any current physical problems? Y N If yes, please explain._____

Development History (*was child planned)*

List any problems with pregnancy (*spotting, drugs, illnesses)*: _____

_____

Delivery:
*Premature*____*Full Term*_____*Overdue*_____*Normal*_____*Cesarean*_____*Breech*____
*Weight*_____ *Length of Labor*_____

Complications (*toxemia, Rh factor, Forceps, jaundice, other* _____

Did mother and baby come home together? Y N Were you able to enjoy baby? Y N

Did you have "*baby blues*"? Y N

Please describe any problems in your child's first year of life:_____

_____

How soon after birth did mother begin work? _____
Full Time _____ *Part Time*_____
Who cared for child?_____
Why did she go back to work? _____

Age child began to talk? _____ Age child began to walk? _____
Age toilet training began? _____ Completed? _____

Whom have you previous consulted about your present problem(s)? _____
_____

Personal Data:
*Date of Birth:*_____ *Place of Birth:*_____

Underline any of the following that applied during childhood:

Night terrors	*Bed wetting*	*Sleep walking*
Thumb-sucking	*Nail-biting*	*Stammering*
Fears	*Happy childhood*	*Unhappy childhood*

Any Others:

Who is Primary Disciplinarian? _____ Do Parents Agree on Discipline? _____ What Disciplinary Measures are Used by Each Parent (*how are they applied):*

Relationship with Siblings (*how get along with each other):*

Relationship with Peers:

Do they tease your child? Y N *What names do they call your child?*_____
_____*Does your child have a best friend?* Y N

Does child feel like you are fair when you punish him? Y N

Who is stricter? _____

How do you punish your child? _____

*Who are the most important people to your child?*_____
_____

Fears: _____
_____

Favorite Activities: _____
_____

What kinds of things make him happy? _____

What kinds of things make him sad? _____

What kinds of things make him angry or upset? _____

Changes (*what I'd like to change in my child):*_____
_____
_____

Dreams, Daydreams, Nightmares:_____
_____
_____

Health during childhood?

List illnesses:

Health during adolescence?

List illnesses:

Any surgical operations? Y N
Please list them and give age at time.

Description of Early Stages

Infancy (feeding, sleeping, crying, cuddling):

Toddler (toilet training, curiosity, play):

Pre-school (separation problems, relation to siblings and peers):

School Adjustment (*behavior and grades to present, any testing or special education, attendance, relationship with authority)*:

Peer relations:

Sibling relations:

Positive aspects of child:

Please describe any physical or mental problems:

Has your child been depressed? Y N Suicidal? Y N
Homosidal? Y N Had difficulty with the law? Y N
Drug Usage? Y N Alcohol usage? Y N

How sees problem (*why he thinks he is here):*

School (*feelings about school work, relationship with teachers, classmates)*:

Description of Relationship with Father (*include what they do together, how much time they spend together, what father does when angry with youth, what youth does when angry with father, how youth feels about relationship)*:

Description of Relationship with Mother (*include above):*

Description of Relationship with Step-parent, Grandparent, Significant Others (*include above)*:

If divorce, death or separation, how was it explained and how does youth feel about it?

Martial and Family Events (*including reason why parents married – note ages of child during specific crises, moves, hospitalization, separations, etc. note how child reacted to these crises)*:

General Home Atmosphere-Marital Relationship – How Spouse Describes Mate's Personality: