

David Palaia, MS, LPC-MHSP, NCC



Professional Counseling

David Palaia provides high-quality, affordable counseling services to individuals, couples, and families. I hold a Master's Degree in Mental Health Counseling from Montana State University, which has been accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP), and I am licensed in the state of Tennessee as a Clinical Professional Counselor and Mental Health Service Provider.

Please sign your name on the following page after you read, understand, and agree to the following. Please discuss any questions you may have with the counselor before signing.

I understand that my first session with David Palaia is evaluative only and does not imply that we have entered into a therapeutic relationship. I understand that treatment with David Palaia is completely voluntary and usually involves discussion of issues that are times uncomfortable. However, I also understand that this process is to help me personally and to help me resolve concerns I have about myself and with my family members, partners and other persons. I understand that my counselor may use different applicable treatment methods including discussion, education, relaxation, and visualization as well as recommend reading and other activities for outside the therapy session. I understand that my counselor is only there to help me explore and resolve difficult life issues and that my motivation and participation in this process are essential. I understand that my counselor cannot guarantee improvement of my situation, and at times I may feel worse before feeling better. If at anytime this process feels too intolerable, I will discuss this with my counselor. I also understand that although our sessions will involve discussing things of an intimate nature, I realize that we have a professional, rather than personal, relationship and that my relationship with my counselor will be limited to our sessions together. I understand that giving gifts and/or socializing with my counselor is inappropriate. I understand that if I see my counselor outside of session, he will not initiate contact with me and that it is inappropriate to discuss therapeutic matters with him.

I understand that all identifying information about my assessment and treatment is kept confidential. However, I also understand that information about my case may be shared with other licensed mental health professionals for treatment purposes only and that my name(s) and any other identifying information will not be shared. In order to protect confidentiality, any written, telephone, or personal inquiries about clients will not be acknowledged. I understand that I must give verbal and written agreement before any identifying information

will be revealed to anyone. Further, I understand that there are four conditions under which my counselor may breach confidentiality without my permission: 1) in the case that he has reason to believe that I am at risk of doing serious harm to myself, 2) in the case that he has reason to believe that I am at imminent risk for doing harm to others, such as committing a serious legal offense (e.g. homicide), 3) in the case that he has reason to believe that a child under the age of 18 is being\has been physically abused, sexually abused, or neglected by any person or that there is suspected abuse of an elderly or disabled person, 4) in the case that he is ordered to do so by a judge in a court of law. I give my consent for my counselor to contact ANY PERSON in a position to prevent me from doing harm to myself or someone else including but not limited to the police, a physician, family member, close friend or other mental health professional.

I understand that personal information will be entered into my file in written form. My file will be kept confidential and is subject to the same limits to confidentiality as noted above. In the case of couples or family therapy, I understand that my counselor will keep one file to be accessed by any of the clients upon request. If for some reason there is a need to share information in my file with someone (e.g. another mental health professional with whom I am working, physician, etc) I will first be consulted and asked to sign a release of information form. In the event that my counselor should die or become incapacitated, I give permission for Gayden Fite LPC-MHSP – 615-440-8909, to take possession of my chart and maintain the same standards of confidentiality as my counselor. If I have any questions about confidentiality, I will discuss them with my counselor.

Further, I understand that after-hours services and emergency services are not available from David Palaia. My counselor may not be able to return phone calls immediately or schedule immediate treatment. If I have such an emergency and am unable to contact my counselor, I can call 911 or go to the emergency room. I understand that if David Palaia determines that he is unable to meet my needs for whatever reason, I will be provided with the referral information for other mental health professionals.

I understand that David Palaia charges _____ per session. **I understand that payment for services are due in full at the end of each counseling appointment. I will notify my counselor 24 hours in advance should I need to cancel or reschedule an appointment. I understand that I will be billed at half my normal rate for not showing up for an appointment without notification. I understand that non-payment could be a reason for termination of counseling.** I understand that my time missed due tardiness can not be added to my session. I understand that if I wish to have my insurance billed, my counselor will fill out the necessary paperwork and that I will be responsible for any co-payments, deductibles, etc. Health insurance companies usually require a diagnosis for a mental health condition in order to reimburse for services. I understand that this diagnosis will be included in my insurance records if I choose to use my insurance for payment. Further, should there be any reason for David Palaia to testify in a court of law or give a deposition in any case regarding a client past or present, the rate for this will be two times the normal session rate regardless of fee scaling or insurance which amounts to 240 dollars per hour for time in court and three times (360 dollars) for time giving testimony or deposition. Also should the a court matter be involved, I understand that David Palaia will require s 500 dollar retainer paid in full in advance of court testimony or deposition. I also understand that

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

David Palaia, M.S.
Licensed Professional Counselor

I, _____, understand and have been provided a copy of Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

Patient Signature or Parent if Minor or Legal Charge
If Legal Charge, describe representative authority: _____

Date

INTAKE INFORMATION

Patient _____		
_____	_____	_____
_____	_____	_____
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age: _____
SS#	_____	DOB _____ / _____ / _____
Ethnicity:	<input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Pacific Islander	
Education: _____ yrs.	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Yrs.: _____
Address: _____ Apt. # _____		
_____	_____	_____
_____	_____	_____
_____	_____	_____
Home Phone: () _____	May we contact you at Home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Work Phone: () _____	May we contact you at Work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cell Phone or Pager: () _____	May we contact you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address: _____	May we contact you at this address?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(Note: address is never shared and this is voluntary and intended for future patient satisfaction surveys to improve our service)		
Name of Employer: _____	Occupation: _____	
Name of Insured if Different: _____	Relationship: _____	
Insured's Social Security Number: _____	DOB: _____ / _____ / _____	
Insured Address if Different: _____		
Insured Employer: _____	Phone: () _____	
Who Referred You: _____	Phone# _____	
In Case of Emergency, contact: _____	Relation to you: _____	
	Phone# _____	
Primary Care Physician: _____	Phone # _____	
Pharmacy _____	Phone# _____	

Presenting Problem: _____

Do you have any current or long term medical conditions? _____

Have you ever received treatment from a mental health professional or physician before? (if yes, when and where)

