Richard H. Stout, MS, LMHC

Adult * Child * Adolescent Psychotherapy
Florida Licensed Mental Health Counselor # MH3568
Certified Clinical Criminal Justice Specialist #14018 by the National Assoc of Forensic Counseling
Certified Traumatologist #1103 , Florida Supreme Court Certified Divorce Mediator #4938F

Offering TELEHEALTH SERVICES on HIPPA Compliant DOXY.ME Platform

Call **407-323-0027** Website**: richardstout.com**
Appointments, Re-schedules, Cancellations: RSTOUTEAP@aol.com
Billing and Administrative matters: Richardstoutadm@aol.com

Information about the Patient

First Name _____ ***MI*** _____ ***Last*** _____

Date of Birth _____ / _____ / _____ ***SSN*** _____

Please circle *[MALE - FEMALE]* *[SINGLE - MARRIED - SEPARATED - DIVORCED - WIDOWED)*

Address _____

City _____ *State* _____ *Zip* _____

Best Contact Phone Number _____*May we leave a message?* _____

Email Address (please print legibly!): _____

May we contact you at this email? ***YES / NO***

****** *Emergency Contact Person Name AND Phone Number* _____

Information about the Insured / Responsible Person (IF DIFFERENT FROM PATIENT)

First Name _____ *MI* _____ *Last* _____

Relationship to Patient _____ ***EMPLOYER*** _____

Date of Birth _____ / _____ / _____ ***SSN*** _____

RELEASE OF INFORMATION

I authorize release of any information necessary to expedite payment of insurance claims. I understand that I am ultimately responsible for any/all charges, regardless of coverage, and understand that any unpaid charges will be sent to Medical Collections.
I authorize payment of medical benefits to the office of Richard H. Stout., MS, LMHC.

Signed *(Patient, Parent or Guardian)*_____ *Date* _____

CONSENT for PSYCHOTHERAPY TREATMENT and STATEMENT OF UNDERSTANDING

I certify that I have the authority to legally consent to Psychotherapy treatment with Richard H. Stout MS, LMHC, and by my signature below, I am giving this consent. Further, I understand and agree that the first office visit is purely for evaluation purposes, and that the counselor is not obligated in any way to continue to treat me. I hereby give Richard H. Stout permission to perform this evaluation and conduct further treatment as deemed necessary. I understand that I am ultimately responsible for any/all charges, regardless of coverage, and understand that any unpaid charges will be sent to Medical Collections. I agree to give at least 24 hours notice of cancellation of any appointment - Otherwise I understand that I will be billed the FULL charge for the session that was reserved for me.

Signed *(Patient, Parent or Guardian)*_____*Date* _____

Richard H. Stout, MS, LMHC

Statement of Understanding

(2025)

Welcome to the office of Richard H. Stout, MS, LMHC, Florida-Licensed Psychotherapist. Our primary focus is to provide a safe, confidential and therapeutic environment in which you may effectively and efficiently deal with your issues. With this goal in mind, and to eliminate any misunderstandings, the following are general practice guidelines for your review and signature(s). Suggestions and/or questions are welcomed anytime. Thank you for the opportunity to participate in your care.

PRACTICE GUIDELINES

Your first office visit is for evaluation purposes. While you should expect to benefit from this treatment, understand that due to factors beyond our control, particular outcomes cannot be guaranteed. The patient understands and agrees that consistent and regular attendance, along with compliance with treatment assignments and recommendations will produce the maximum benefits. The patient has the right to ask any questions about their care. I/we understand I/we am/are free to discontinue treatment at any time. If you decide to do so, you will notify this office at least two (2) weeks in advance so that effective treatment planning for continued care can be implemented.

FINANCIAL INFORMATION AND BILLING POLICIES

Initial Evaluations are billed at $150, and subsequent sessions are billed at $125 per 45-50 minute clinical hour. Therapy services provided in different time durations, Report /Letter Writing and/or Crisis Calls are pro-rated at the rate of $110 per clinical hour.

I, the patient, understand that I am responsible for payment of services rendered, regardless of whether that service is covered by an insurance policy, and I agree to pay these costs regardless of any disputes with my Insurance Company. While it is our pleasure to bill your Insurance/EAP as a courtesy, final payment for our services is ***ultimately your responsibility.***

***INITIALS** ☐

I understand that I ***will be charged for appointments not cancelled 24 hours prior to the appointment time.*** I understand that past due debts may be forwarded to a Medical Collection Agency for recovery. ***INITIALS** ☐

Per Office Policy we obtain CREDIT CARD PRE-AUTHORIZATION for Co-Pays & Deductibles at Point of Service,
And/or Card Will Be Charged for Missed Appointment Fees or Balances Due over 30 Days.
****You may revoke this authorization at any time by written request.*

Name on Card: _____

Card#: _____

Exp. Date: _____ CVC _____ Zip _____

CONFIDENTIALITY

No one will reveal information concerning your psychotherapy care, except as follows: (1) You consent in writing, (2) Your life or safety is threatened, (3) disclosure is required by law, or (4) information is required by your Insurance Company regarding a claim for our services. ANY AND ALL INFORMATION - PERSONAL, MEDICAL OR OTHERWISE - WILL BE HELD IN THE STRICTEST CONFIDENCE.

I have read and understand this Statement of Understanding and will abide by all the above guidelines.
A copy of this signed sheet will be provided to me upon request.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date :** _____

Richard H. Stout, MS, LMHC

NOTICE OF PRIVACY PRACTICES
Receipt and Acknowledgment of Notice

Patient Name: _____

DOB: _____ **SSN:** _____

As a patient, I understand that I have certain rights and responsibilities as it relates to my privacy and healthcare. I understand it is important to know those rights and responsibilities.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of "Notice of Privacy Practices" of the Offices of Richard Stout, M.S., L.M.H.C. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact Richard directly.

_____ _____

Signature of Patient/Client ***Date***

OR:

_____ _____

Signature or Parent, Guardian or Personal Representative* ***Date***

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.) _____

OR:

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____ _____

Signature of Staff Member ***Date***