

Healing The Broken Heart, LLC



~ Mission Statement~

Mission: The seed of Healing The Broken Heart, LLC was planted in 2015 and bloomed on September 13th, 2019 with the mission to invest in individuals and children by promoting wellness, inspiring strength, and getting them back to being active with the help of the Lord.

Vision: Although, there are numerous residential housing programs across the Tampa Bay area which provides the community with a variety of resources and services; very few provide a comprehensive (wrap-around) program or are always full. The ultimate vision for HTBH is to provide more than just counseling services to the community, but to collaborate/contract with like minded community organizations and businesses around the Tampa Bay area and establish a comprehensive residential housing program for families that will help bring healing to our city's broken heart.

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~Community Served~

HTBH offers a variety of counseling services in confidential settings (library room, conference room, etc.). Each session consists of 1-hour face-to-face/telehealth interaction with the Registered Mental Health Counseling Intern using cognitive behavioral techniques/ strength based approach from a biblical perspective.

1. **Single Mothers** Being a mother is a lifelong calling that comes with seasons. These seasons can be glorious at best and downright stressful at worst. According to a research article by Stack and Meredith (2018), the stress that single mothers face often results in going without food, isolation, anxiety, depression, paranoia, and suicidal thoughts. The article goes on to say that support for single mothers in general such as a therapeutic outlet with more direction would be beneficial. HTBH is designed to provide mothers with therapeutic strategies to empower and encourage them through their season of parenting. Refer to the appointment and fees section in the informed consent page for more details.
2. **Teen Sessions.** Growing into adulthood can be both exciting and challenging for teens and their families. In extremely challenging times, families need to know that they don't have to go at it alone. HTBH Teen sessions are designed to meet teens where they're at from ages 10 to 17 years old. Sessions can take place at the child's school, or any confidential area with the consent of a parent or legal guardian. Sessions will include conversations about real life situations, struggles, goals, and to implement a positive outlook for future generations.
3. **Trauma Caregiver Support-** HTBH realizes that PTSD is a going battle that not only affects the sufferer, but their families and community as a whole. We are grateful to the men and women and their families who served our country through the Armed Forces and First Responders and will provide counseling services for caregivers. According to the Department of Veterans Affairs "prolonged or severe cases of PTSD can cause family members to feel burnt out or suffer from "caregiver burden" (Ramirez-Wylie, 2013). HTBH will equip caregivers with the skills and care plans they need to avoid "caregiver burnout" and to help them support their loved ones battling with PTSD. Refer to the appointment and fees section in the informed consent page for more details.
4. **Group Sessions-** Each session can be conducted as group counseling at no charge. Sessions will run for 45 minutes on a weekly basis or occasionally. The topics can range from various topics such as healthy relationships, implementing self-care, creating family time, and more.
5. **Individual Sessions.** HTBH provides individual counseling sessions for women who feel they will benefit the most from private individual sessions. Personal development, trauma recovery, coping skills, and healing will be processed together with empathy.



~ Client's Informed Consent and Information Page~

Please take the time to read and ask questions before consent is granted.

HTBH Purpose of Counseling: As stated in the mission statement, the mission is to invest in women and families by promoting wellness, inspiring strength, and getting them back to being active with the help of the Lord. With that being said, it is YOUR right as a client to know the credentials and what to expect from the individual that is providing counseling services to you. HTBH is a faith-based Christian Counseling practice that serves its diverse community. It derives its counseling techniques from Cognitive Behavioral Therapy, Strength Based Approach, and Biblical applications. You as the client have the freedom to choose whether to enter into or remain with counseling services through HTBH.

Counseling Intern's Credentials: Candace Edwards received her M.A. degree in Clinical Mental Health Counseling on June 23rd, 2019 and is currently a Registered Mental Health Counseling Intern (IMH 18911) under the state of Florida. Candace currently receives state mandated supervision by a qualified supervisor who is a Licensed Marriage and Family Therapist. Upon passing the National Clinical Mental Health Counseling Exam and completing 1,500 hours of counseling clients, Candace will be a Licensed Mental Health Counselor.

Times of Availability: Currently counseling sessions are by appointment only. Every client deserves undivided attention during sessions, **life threatening emergency phone calls should be made to 9-1-1 or the Suicide Hotline at 1-800-273-8255 immediately.** Do leave a voicemail (813) 586-4339 and your call will be returned within 24-48 hours.

Appointments and Fees: Counseling sessions are 45-60 minutes depending on travel time. Appointments are arranged on a first come first served basis and areas that are served are Tampa, Riverview, Valrico, Seffner, Brandon, and Plant City. HTBH gives ALL potential clients a free consultation session. We know "life happens" and canceling your appointment is understandable. HTBH asks that you DO NOT make it a habit of canceling at the last minute. This prevents other clients from using that much needed time, please be considerate. You can cancel or reschedule by calling the following number (813) 586-4339 and leaving a message and your call will be returned. After 3 consecutive reschedules/no-shows, you will be referred to other resources that are available. If the Registered Mental Health Counseling Intern will be out or on vacation, you as the client will be notified and sessions can be rescheduled for another day or another counseling professional can fill in for the session.

Unfortunately, at this time HTBH is not able to accept any insurances and is a pay per session service and payment will need to be rendered **BEFORE** session begins. In person counseling and Telehealth counseling are \$50.00 a session. Group sessions/speaking events are free of charge. HTBH has a scaling fee option ranging from \$40-45 per session and will be permitted on a case by case basis. HTBH is also an ASO service provider through the Children's Board of Hillsborough County and can be used as an in-home parental instructor for free. Please contact the Children's Board of Hillsborough County for more information at (813) 229-2884.

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Confidentiality (HIPPA): According to the state, federal law, and the ACA Professional Code of Ethics, you as the client have a right to keep what you communicate in session private. Your record will not be shared with anyone unless you give written permission do so. There are a few conditions regarding confidentiality such as:

•**Emergencies:** Your protected health information will be shared if there is an emergency as needed to enable people to care for you. Otherwise you must sign a release of information to be able to talk to any family, friends, etc.

•**Disclosure to health oversight agencies:** HTBH is legally obligated to share protected health information to certain government agencies, including the Federal Department of Health and Human Services.

•**Disclosure to child protection agencies:** HTBH will share protected health information as needed to comply with state law requiring reports of suspected incidents of child abuse or neglect, elder abuse or neglect, or abuse or neglect of a person who has a disability and is not able to care for themselves. If you seriously threaten to harm another individual, HTBH has a duty to warn that individual and the authorities. If HTBH received a court order to testify about you, this must be addressed. If you as the client are being treated under court order, your file must be reported to the court.

Due to confidentiality, I am unable to respond to your emails regarding counseling issues to an extent.

Social Networking: HTBH does not accept friend requests from current or former clients on social network sites, such as Facebook, LinkedIn etc. This is a safeguard to prevent a breach of confidentiality and tarnish the therapeutic relationship between client and Registered Mental Health Counseling Intern.

Record Review: HTBH is required by Florida law to maintain clients records for seven years. If you as the client have concerns regarding your treatment records, they can be reviewed with the Registered Mental Health Counseling Intern. The review can take place anytime with the exception if there are legal proceedings, emergency circumstance, or if the information is considered detrimental to the client's wellbeing. In the event this happens, HTBH will transfer your records to an appropriate mental health professional of your choice.

Treatment Plans: The first few sessions of counseling will be focusing on building the therapeutic relationship with the client. This will include areas of strengths, weaknesses, and a diagnosis if applicable. A treatment plan will be created with possible goals and will be discussed between the client and the Registered Mental Health Counseling Intern. The discussion will address possible risks and benefits with the treatment plan that is selected agreed upon. You as the client have a right to ask questions or voice your concerns with the chosen treatment. As discussed in the beginning of the booklet the technique that will be used is Cognitive Behavioral Therapy, Strength Based Approach, and Biblical applications.

Termination of Counseling Services: You as the client have the choice to discontinue the counseling sessions at any time. HTBH would ask that you discuss this with the Registered Mental Health Counseling Intern and complete a feedback survey to ensure that HTBH is addressing concerns and improving in target areas. After a series of sessions are complete, an overall progress assessment will be completed. During this time, if it is apparent that positive progress has not been made, a referral for more services can be made under the following terms: If you as the client are not satisfied with the progress of the counseling relationship, you are not actively participating in the counseling process or assignments, or if your situation or circumstance is out of the scope of

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practice of the Registered Mental Health Counseling Intern. Your file will be closed after 30 days if you do not respond to 3 attempted correspondence.

Minors (Teen Sessions) HTBH uses the same confidentiality protocols for minors, as for adult clients. You as the parent or legal guardian have a choice to enter your child into a therapeutic relationship with HTBH. You as the parent or legal guardian have a right and responsibility to understand and ask questions about the therapeutic practices that are taking place with your child. However, as a parent or guardian, you have the right and responsibility to question and understand the nature of therapeutic activities and the progress of your dependent. At this time HTBH nor the Registered Mental Health Counseling Intern is **NOT** qualified to handle legal custody disputes or testify in legal court proceedings. However, the parent or legal guardian who has signed the informed consent for the child will have correspondence with the Registered Mental Health Counseling Intern. However, if you are involved in domestic litigation or become a party to a divorce or custody action, HTBH will only work with one legal guardian or parent with the consent of treatment for the child.

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~CONSENT FOR THERAPY SERVICES WITH HTBH~

I, _____ am choosing to participate in therapy services with HTBH for myself or for my child. I do understand that any information received will be confidential with the exception of legal requirements for disclosing this information. I do understand that I can authorize release of information by completing a written consent form. I have the right to terminate from therapy with HTBH at any time, without prejudice which would void this consent for therapy services. I do understand that I have the opportunity to ask questions about the foregoing to my satisfaction. Counseling is a journey and goals often change, and there is no guarantee that the goals will be attained, however we will strive our best to achieve them. The more proactive involvement, the more effective counseling will be to you. We will establish goals for your therapy. By signing below, you agree to work toward the goals in your daily life and to use the counseling sessions to achieve your goals, which will be reviewed periodically.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE AND AGREE TO THESE CONDITIONS.

Client's Name (print): _____

Client's Signature. _____

Date: _____

Client's Name (print) if a minor _____

Parent or Legal Guardian Signature _____

Date: _____

Registered Mental Health Counseling Intern

Name(print) _____

Registered Mental Health Counseling Intern Signature: _____

Date: _____



References

Single Mothers articles from J. Fam Econ Issues. 2018;39(2): 233-242. The Impact of Financial Hardship on Single: An Exploration of the Journey from Social Distress to Seeking Help. Stack, R.J. Meredith,A. Retrieved from www.ncbi.nlm.nih.gov.

PTSD articles retrieved from Ramirez-Wylie, J. (2013). PTSD and Its Role Reversal Effect on Family Caregivers. Article retrieved from www.army.mil.

Additional articles from Cremades, A.(2019). Why Entrepreneurship Involves Depression (And How to Overcome It). Article retrieved from www.forbes.com



Client Emergency Contact Form

In case of an emergency, list three emergency contacts below (if you do not have three, list who is necessary) :

1. Contact Name _____

Phone Number _____

Relationship to client _____

2. Contact Name _____

Phone Number _____

Relationship to client _____

3. Contact Name _____

Phone Number _____

Relationship to client _____

In case of an emergency location, please list the hospital you prefer to be transported to:

Do you have a Primary Care Doctor? Y _____ N _____ If so, what is the doctor's name

_____ Doctor's contact _____



INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth (A separate telehealth informed consent will be provided to sign). If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone’s well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Fees for telehealth sessions are the same as face-to-face sessions.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the Coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ride sharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take and participate in certain precautions which will help keep everyone (you, me, and our families) safer from exposure to sickness and possible death. HTBH has safety precautions such as masks, 70% hand sanitizers, Lysol spray, and infrared thermometer, 6 feet apart, to be used during each face-to-face session. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

You will only keep your in-person appointment if you are symptom free. Initial _____

You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the Coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, you will not be charged.

You are more than welcome to wait in the downstairs main lobby area of the building and I will come and meet you and escort you to our session room. Your temperature and hand sanitizer will be utilized before we proceed to our session room. A mask is required for the session and if you do not have one, one will be provided for you.

Initial _____

Unfortunately at this time no childcare will be provided and session maybe rescheduled or moved to telehealth sessions if childcare cannot be obtained

Client Signature _____

Date _____

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HIPAA RELEASE OF FORM

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

OR

b. all past, present, and future periods.

3. Extent of Authorization

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. I authorize the release of my complete health record with the exception of the following information:

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment



Nothing Else Follows