Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

Counseling Services Information

Who We Are

Lunday Counseling Center is a faith-based counseling center committed to providing counseling and life coaching that is founded on Christian principles within a comfortable, confidential atmosphere. Dr. Mindi Lunday and her team are Christians who integrate therapeutic skills with a solid biblical foundation.

Dr. Lunday is a Licensed Mental Health Counselor Supervisor, a Registered Play Therapist Supervisor, and Licensed Professional Counselor with a Doctorate in Counseling Psychology and two Master's Degrees – Master of Arts in Marriage and Family Counseling and Master of Arts in Education. Lunday Counseling Center houses Doctoral and Master's level therapists and Certified Life Coaches, offering a variety of services and is here to serve individuals, couples, and families, including children, adolescents, and adults. However, if you feel that services are not being rendered adequately, please discuss this concern with your therapist or life coach. If no change takes place, complaints regarding licensed therapists can be made to:

State of Florida Department of Health 850-245-4339
(The above State of Florida Department of Health receives questions and complaints regarding services by licensed professionals at the indicated number.)

Confidentiality

It is important for you to understand that all identifying information about the clients counseling therapy/treatment is kept confidential. Information regarding your case is only shared with those professionals (i.e., supervisors and consultant counselors) who will confer with your service provider and thereby enhance the services you receive.

In order to protect client confidentiality, we adhere to the following procedures:

1. Written, telephone, or personal inquiries about clients will not be acknowledged without permission. You must sign a release before any information about you is given to anyone outside the counseling center. Even then we may advise you to withhold information if we feel it is in your best interest.
   ____ (Initial)

2. All records, tapes (if apply) or other identifying materials are kept confidential. Records are destroyed seven years from the end date of services, unless the client is a minor. In this case records are destroyed seven years from the date he/she turns eighteen. ____ (Initial)

3. Recordings (if made) are routinely erased and records are destroyed on a regular basis as provided for in Florida law. ____ (Initial)

4. Legal limits to confidentiality are observed. ____ (Initial)

5. Confidentiality cannot be guaranteed through email or texting and is not LCC policy to correspond through such avenues. Should you choose to send correspondence with your therapist using electronic methods you do so at your own risk and LCC will not be held responsible for breaches. ____ (Initial)

6. Lunday Counseling Center is a teaching center; therefore aspects of therapy sessions may be addressed during supervision or consultation in order to better serve the client. Special care will be taken to protect the client when this occurs. _____ (Initial)

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Service Policy

Calls placed to therapists and coaches will be primarily for the purpose of scheduling or rescheduling appointments. Non-emergency calls placed to the counselors will be returned within 24 hours Monday through Thursday. Calls placed Friday through Sunday will be returned by the following Monday. ____ (Initial)

In emergency situations (i.e., situations where someone is out of control, has ideas or plans of self harm or of harming others, or demonstrates potentially harmful behavior) the client should dial 911 or go directly to the nearest hospital emergency room. ____ (Initial)

When cancellation of a session is unavoidable, it is important for the client to notify the therapist or coach 24 hours in advance. Standard fees will be applied when 24 hours has not been provided. ____ (Initial)

Fees will be charged on credit card provided on any no show or late cancelation appointments. ____ (Initial)

Consistently missed appointments (barring bona fide emergencies) or failure to complete counseling homework assignments on a regular basis may result in termination of the counseling relationship. ____ (Initial)

Therapists with Lunday Counseling Center will not testify in court. If subpoenaed by the judge, they will not appear in court unless the retainer is received 3 days prior to court date. Hourly court fees will apply if additional appearances are needed as well as hourly charges related to preparation for court. These fees are not the same fees as 50 minute counseling sessions. See below. ____(Initial)

If your child is the client, it is your responsibility, as the parent, to maintain contact with the therapist regarding progress and questions you may have. It is recommended that if these questions require more than 5-10 of the therapist's time, scheduled appointments with the therapist are recommended and available upon request. ____(Initial)

When working with children of divorce and a change in schedule is requested, the therapist ***will not*** be responsible for contacting the other parent regarding changes. This duty will fall on the parent requesting the change. _____(Initial)

Court and Court related fees

LMHC (Licensed Mental Health Counselor)
$2,500 for each day subpoenaed to be **paid three days prior to appearance**.
$150 an hour for court preparation.
Expert Witness fees separate and available upon request.

In order for counselor to appear in court, counselor must have subpoena signed by a judge as well as any other court related fees, received and paid in full, a minimum of 3 business days prior to court date. As additional fees incur, fees will be billed accordingly.

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Consent to Disclosure of Information Waiver of Confidentiality,
Patient/Client Form

By signing this document, I give the following names and/or organizations permission to discuss my therapy for the advancement of my treatment.

I, _____, give my consent in regard to myself and/or my minor child,

_____, for _____

(minor's name if applicable)

to discuss the following specific information:

€ Medication information	€ Nutrition information
€ Treatment plan	€ Financial assistance information
€ Discharge plan	€ Other _____

_____ _____
Name of organization Contact person Phone

_____ _____
Mailing address

Specific purpose: _____

This consent is subject to written revocation at anytime except to the extent that action has already been taken upon this consent. This consent will expire on _____.

I specifically release the above parties, counselors, and Lunday Counseling Center, from any civil or criminal liability or responsibility as a result of having released the requested information pursuant to this signed consent.

_____ _____
Signature Date

_____ _____
Witness/Counselor Date

Notice to recipient of information: The information disclosed to you was taken from records of which the confidentiality may be protected by State and/or Federal law. State and Federal laws prohibit you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by State and Federal regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

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Credit Card Consent Form

I, _____, give my expressed permission for any session fees, including and not limited to in and out office sessions, phone sessions, no show's, incurred by the following person(s):

_____

_____

_____

to be charged to my credit/debit card (information below) for sessions with Lunday Counseling Center.

____ I understand and agree that if my credit card is declined for any reason, I will pay with another (initial)card or may be asked to pay with cash or check.

Credit/Debit Card Information

Name (as appears on the card): _____

Card type: _____ Zip code of card holder: _____

Card Number: _____

Expiration date: _____ CSC # (3 digit number on back of card) _____

Signature of card holder: _____

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Fee Structure

By initialing below I agree that I have read and understand what my responsibilities are financially to Lunday Counseling Center.

_____ **Fees**: Individual Session:

Doctoral Level:	$150 for 50 minute session $25 for every 15 minutes after 60 minutes
Master's Level	$125 for 50 minute session $25 for every 15 minutes after 60 minutes
Licensed Intern	$100 for 50 minute session $25 for every 15 minutes after 60 minutes
Marriage & Family	$150 for a 50 minute session $25 for every 15 minutes after 60 minutes
Joint Therapist/Coach	$100 per therapist/coach, per session
Phone consultation:	$25 for every 15 minutes

- Weekend and Emergency Visits – add $100 to standard fee
- Rates are subject to change in 6 month increments
- $25 return check fee
    - If check is returned as NSF, counselor may ask for cash or cashier's check for future payments.

_____ (Initial) I understand that I will be charged for any "no show" or failure to provide advanced notice of 24 hours for any appointment I do not keep. I agree that the credit card that I will provide will be charged **full fee** for "no show" or failure to provide 24 hour notice.

- 3rd no show or failure to provide 24 hour notice could result in termination of therapy

(Client may file out of network insurance for all sessions and receive reimbursement from his or her insurance company, dependent on specific plans/companies. *These receipts will be provided at the end of each month for those who make requests*. HOWEVER – INTERNS CANNOT TAKE INSURANCE!!)

_____ _____ _____
Client/Parent/Guardian signature Relation to client Date

_____ _____
Witness (Counselor) Date

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Limitations of Client-Therapist Confidentiality

Confidentiality is of the utmost importance where the client-therapist relationship is concerned. We believe that it is important that the client be able to assume that their private communications with the therapist be kept confidential. However, there are certain exceptions, which supersede the confidentiality of the client-therapist relationship. It is our ethical obligation to inform you of the exceptions.

Exceptions to Confidentiality:

1. The therapist makes an assessment of an impending suicide risk. (491.0147 – Florida Statutes)

2. A client reports past or present instances of the abuse or neglect of a child, elderly person, or mentally challenged person. (Chapter 39.201, Florida Statutes)

3. A client acknowledges committing abuse or neglect of a child, elderly person, or mentally challenged person either in the present or in the past. (Chapter 39.201, Florida Statutes)

4. There is a probability of imminent harm to the client or others. (491.0147 – Florida Statutes)

5. Counseling records may be released when a Judge subpoenas them.

6. When a complaint has been filed against the therapist. (491.0147 – Florida Statutes)

I have read the preceding statement and understand that under the above stated circumstances the confidentiality of the client-therapist relationship is superseded. I understand that in such instances my therapist is bound ethically and legally to inform the proper authorities.

Client Signature: _____ Date: _____

Client Name Printed: _____

Parent Signature: _____ Parent Name Printed: _____

Witness/Counselor Signature: _____ Date: _____

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Informed Consent

I understand that counseling may involve discussing relationship, spiritual, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with relationships. I am further aware that Lunday Counseling Center is faith-based and utilizes Biblical principles throughout the treatment process. I am aware that there are alternative treatment facilities available to me.

My therapist has satisfactorily answered all of my questions about counseling. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may end therapy at any time, although I have been informed that this is best accomplished in consultation with the therapist.

In signing this form:

a) I understand and agree to the services at this center being provided by doctoral or master's level, licensed or intern, counselors. This may include case consultation and review of treatment notes.

b) I understand that Lunday Counseling Center is a faith-based organization and agree with the use of Biblical principles throughout the treatment process.

c) I understand the confidentiality policies and I agree to them.

d) I understand and agree to the fee structure for counseling services.

e) I understand that any service rendered is my responsibility.

f) I understand that my role as a client is:

1) To be honest during counseling sessions, complete homework assignments, and demonstrate a willingness to change. I understand that what I put into counseling, I will get out of counseling.

2) To refrain from the use of alcohol or drugs while in counseling.

Client Signature: _____ Date: _____

Client Name Printed: _____

Parent Signature (if applicable): _____ Parent Name Printed: _____

Witness/Counselor Signature: _____ Date: _____

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Notice of Privacy

I have read and understand the Notice of Privacy (HIPAA) that I received with the paperwork provided by Lunday Counseling Center. I understand that I can receive an additional copy by requesting a copy through Lunday Counseling Center and/or my insurance provider's website.

Print name	Date
Counselor	Date

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Consent for counseling minors

Minor's Name: _____

Date of birth: _____ Age: _____

This is to certify that I give permission to Lunday Counseling Center for the treatment of my child.

This counseling may include individual or group psychotherapy, counseling and testing. This counseling may include consultations with other associates, including Intern's supervisor.

This counseling may also include referrals to other appropriate state and county or professional agencies for further counseling or testing.

X_____ _____ _____
Signature of Parent/Guardian Printed name of Parent/Guardian Date

_____
Street Address/City/State/Zip

_____
Contact number

X_____ _____ _____
Signature of Parent/Guardian Printed name of Parent/Guardian Date

_____
Street Address/City/State/Zip

_____
Contact number

_____ _____
Counselor signature Date

Required Custody Documentation _____ Yes _____ No Date divorce was final: _____