HOPE COUNSELING CENTERS
Winter Haven Office
160 Ave E., N.W.
Winter Haven, FL 33881

Phone: (863) 292-8292
Fax: (863) 292-8283
contact@hopecounselingeap.com
www.hopecounselingeap.com

CHILD CLIENT INTAKE FORM (Please print)

Name: _____Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: □ Male □ Female Date of Birth: _____ Age: _____ Home phone: _____

Mother's Name: _____ Cell phone: _____

Mother's address: _____

Mother's occupation: _____ Work phone:_____

Father's Name: _____ Cell phone: _____

Father's address: _____

Father's occupation: _____ Work phone: _____

Insurance Information:

Insurance Company: _____ Identification Number: _____

Mailing Address: _____ Telephone #: _____

Insured Party (Subscriber Information):

Last Name: _____ First: _____ Date of Birth: _____

Social Security #: _____ Relationship to Client: _____

Mailing Address: _____

Emergency Contact Information:

Name (Someone not living with you): _____ Relationship: _____Home Phone #: _____

Consent For Treatment and Authorization for Assignment of Benefits and Information Release

I hereby give consent to Hope Counseling Centers (HCC) to provide whatever treatment they may deem necessary to the client above. I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy, and should it become necessary to collect these charges through an attorney or other collections process, I shall be responsible for all court costs, attorney's fees and a collection of expenses of no more than 30% of referred balance.

I hereby request payment of authorized insurance benefits and/or any other, including supplemental insurance benefits for me to be paid directly HCC for any services furnished by HCC. I authorize HCC and staff to release to my insurance carrier and its agents any information concerning health care advice, treatment or supplies provided, needed to determine those benefits or the benefits payable for related services.

_____	_____	_____
Guardian Name	Guardian Signature	Date
_____	_____	_____
Guardian Name	Guardian Signature	Date

CHILD CLIENT INTAKE FORM – CONTINUED (Please print)

Does the family regularly attend a church, synagogue, or other religious institution? □ Yes □ No

If yes which one? _____

Grade: _____ School: _____ Teacher: _____

Academic problems: _____

If parents are divorced, when was the divorce final? _____ What is the custody/visitation schedule for client?

_____

Siblings and step-siblings:

Name	Sex	Age or yr. of death	Relationship to client	Living with whom?

Who else lives with you? _____

Please list client's stepparents, or other family members who have a significant effect on client's life

Name	Sex	Age or yr. of death	Relationship to client	Describe him/her

Has anyone in your family been treated or hospitalized for substance abuse or mental health issues? □ **Yes** □ **No**

If yes, explain: _____

_____

Is client currently experiencing any suicidal thoughts? □ **Yes** □ **No**

Has client experienced suicidal thoughts in the past? □ **Yes** □ **No**

Has client attempted suicide in the past? □ **Yes** □ **No**

Is client currently experiencing any violent or homicidal thoughts? □ **Yes** □ **No**

CHILD CLIENT INTAKE FORM – CONTINUED (Please print)

MEDICAL HISTORY: Please list any conditions, illnesses, treatments, or surgeries that might be relevant to reason for seeking counseling:_____

Primary Care Physician's Name: _____ Phone #: _____

Please list all current medications client is taking and the reasons for taking them:			
Name of medications	Dose	Reason for taking	Prescribing Physician

Is client taking these medications according to the doctor's recommendations? □ **Yes** □ **No**

COUNSELING HISTORY: If client has had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use the back if necessary.)

Therapist's Name or Program	Major Issue	Dates

Check off the symptoms or problems that you currently are or recently have experienced:

☐ Stress / Anxiety / Worry / Fears	☐ Parent/child conflict	☐ Nervous movements or twitching
☐ Panic	☐ Other Relational Problems	☐ Seeing Things Others Don't
☐ Depression / Cries a lot	☐ Physical / Sexual Abuse	☐ Hearing Voices
☐ Apathy	☐ Emotional / Verbal Abuse	☐ Drug / Alcohol Use
☐ Fatigue / Lack of Energy	☐ Gender Identity Issues	☐ Deliberately harms self
☐ Loss of Appetite / Overeating	☐ Bad Dreams	☐ Angry / Excessively irritable
☐ Trouble Sleeping / sleeps too much	☐ Unwanted Memories	☐ Frequent temper tantrums
☐ Poor Concentration	☐ Impulsive Behavior	☐ Runs away from home
☐ Feeling Worthless / Low esteem	☐ Restless or hyperactive	☐ Aggressive Behavior
☐ Shyness / easily embarrassed	☐ Obsessive Thoughts	☐ Argues a lot / Lies / Steals
☐ Loneliness	☐ Compulsive Behaviors	☐ Bullying or meanness to others
☐ Clings to adults / overly dependent	☐ Indecisiveness	☐ Truant or suspended from school
☐ Feels need to be perfect	☐ Racing Thoughts	☐ Disobedient at home / school
☐ Learning disabilities	☐ Grief	☐ Cruel to animals/destroys property

Describe why you are coming to counseling and what you hope to gain from this process? (Use the back if necessary)

_____

_____

_____

_____

_____

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PERMISSION TO TREAT A MINOR

Directions: This form must be completed for each minor seen by a therapist. A minor is defined by the law of the state of Florida.

I, _____ (Name of Parent or Guardian) give my permission to _____ (Name of Therapist), to see my son or daughter, _____ (Name of Minor Child), for therapeutic services with or without my being present during sessions. I/We understand that we have the right to control the disclosure of private behavioral health information about my child. However, in the interest of resolving the issues, I/We have brought to the Therapist, I/We give the therapist permission to reveal or withhold information to/from us or others that in the Therapist's judgment is necessary to best help and protect my/our children.

The only exception to this discretion would be in the case of the following:

_____

_____

_____

_____

(Client should write "Not Applicable" in the previous space if NO EXCEPTIONS)

_____
Name of Guardian (print)

_____ _____
Signature of Guardian Date

_____
Name of Therapist (print)

_____ _____
Signature of Therapist Date

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CONSENT TO TREATMENT

I, _____, hereby request to be treated by Hope Counseling Centers, and voluntarily consent to routine diagnostic and treatment procedures.

- Statement of Confidentiality
  Our program maintains a strict policy of confidentiality. The staff protects the privacy of our clients by not disclosing their names, diagnoses, or personal business outside of the treatment setting. We ask that our clients do the same. Persons who attend treatment sessions', including group sessions and what is said in treatment sessions should not be discussed outside the program. Client and staff members SHOULD NOT discuss the identities of those who attend the treatment sessions and/or the substance of comments or statements made in treatment session. There are several additional issues related to confidentiality.

- The staff will not discuss clients and matters relating to their care outside of treatment sessions, but only in private staff meetings devoted to planning and/or supervising treatment, and only among themselves.

- Information relating to a client's diagnosis and treatment will be released to appropriate persons or institutions (such as physicians, insurance companies, etc.) only if client signs consent forms authorizing us to do so.

- All inquiries about our clients, whether by mail, telephone or in person will be responded to with a statement such as: "We cannot release that information," unless we have the client's consent to talk with the person making the inquiry.

- There are rare occasions when we are required by law to suspend our policy of confidentiality:

  - When we have a reasonable basis to believe that a client may be involved in child abuse, we must report this fact to an agency responsible for protecting children.

  - When we have reasonable basis to believe that a client may seriously harm another person (or persons) or him/herself, we are required to take steps to insure that person's safety.

_____
Name of Client or Guardian(print)

_____ _____
Signature of Client or Guardian Date

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FINANCIAL POLICY

Our physicians and therapists are concerned about the cost of your healthcare and want to address some issues related to the cost of medical services in this office. Considerable care has been taken in setting our fees. We want to assure you that the charges accurately reflect the complexity of care rendered and expertise required for you.

HMO and PPO Members: If you are a member of an HMO or PPO in which we participate, your deductible, co-payment/co-insurance is required at the time of service. You are responsible to see that we have a current referral on file if your insurance requires one. If we do not have this referral at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to your Primary Care Physician prior to being treated to obtain a current referral.

If you are not sure it our practitioners are providers for your insurance plan, please look in your insurance directory, or call your insurance carrier, or ask a member of our billing department. (Note: Any insurance that is verified over the phone for benefits is not a guarantee of payment.)

FEE FOR SERVICE: Our policy requires payment of your deductible and/or co-insurance AT THE TIME OF SERVICE.

Our agreement is with you, not your insurance company. Although we submit claims to your insurance company, you are ultimately responsible for payment for the services you receive. Payment to our office to not contingent nor dependent upon your insurance carrier.

APPOINTMENT/NO-SHOW CANCELLATIONS: If, for any reason, you have to cancel your appointment and do not contact our office at least 24 hours in advance of your appointment of it you do not show up for your scheduled appointment time, you or your insurance company could be charged a $50.00 NO SHOW FEE. If you miss three (3) appointments without prior notice to the office, you may be discharged from the care of the physician or therapist at their discretion.

If you have any questions regarding our financial policy, please feel free to discuss them with any of our staff.

I have read and understand my financial responsibly. Should my account become delinquent and be referred to a third party for collection, I agree to pay all reasonable attorney's fees, court cost or a collection expense.

****

_____
Name of Client or Guardian (print)

_____ _____
Signature of Client or Guardian Date

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ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains client rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (863) 709-8110.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Hope Counseling Centers provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The client understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Hope Counseling Centers has a Notice of Privacy Practices and that the client has the opportunity to review this notice.
- Hope Counseling Centers reserves the right to change the Notice of Privacy Practices.
- The client has the right to request restrictions to the uses of their information but Hope Counseling Centers does not have to agree to those restrictions.
- The client may revoke this Consent in writing at any time and full disclosures will then cease.
- Hope Counseling Centers may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

_____

Name of Client or Guardian (print)

_____ _____

Signature of Client or Guardian Date

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SUMMARY NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our pledge to protect your privacy:
Hope Counseling Centers is committed to protecting the privacy of your protected health information. Your care and treatment is recorded in a record. So that we can best meet your mental health needs, we share your record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern mental health care. We will not use or disclose your information for any other purpose without your permission.

Client Rights - You have the following rights regarding your protected health information:

- To request to inspect and obtain a copy of your records, subject to certain limited exceptions;
- To request to add an addendum to or correct your record;
- To request an accounting of Hope Counseling Centers' disclosures of your information;
- To request restrictions on certain uses or disclosures of your information;
- To request that we communicate with you in a certain way or at a certain location;
- And to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose protected health information about you for the following purposes:

- To provide you with mental health treatment and services;
- To bill and receive payment for the treatment and services you receive;
- For functions necessary to run Hope Counseling Centers and assure that our clients receive quality care;
- And as required or permitted by law.

There are additional situations where we may disclose medical information about you without your authorization, such as:

- For workers' compensation or similar programs;
- For public health activities such as:
    - Abuse/neglect of a child, elderly person, or a disabled person
    - Serious threat to health or safety or self or others (e.g. imminent threat for suicide or homicide)
- To a health oversight agency, such as the Florida Department of Health Services;
- In response to a court or administrative order, subpoena, warrant or similar process;
- To law enforcement officials in certain limited circumstances;
- To a coroner, medical examiner or funeral director; and
- To organizations that handle organ, eye, or tissue procurement or transplantation.

Our Notice may be revised or updated from time to time. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices, your rights regarding you medical information, and pertinent contact information.

For further information about the full Notice of Privacy Practices, please contact: Hope Counseling Centers at (863) 709-8110. A complete version of this notice is available on our website at:
www.hopecounselingeap.com/privacy