SCREENING INFORMATION

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY** Readmit: __Yes __No

Date_____ Client's Social Security #_____ Client ID #_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip____

Telephone (Home)_____ (Work)_____ (Cell)_____

E-mail: _____Does HFTMHS have your permission to e-mail appointment confirmations? Yes/No Initials:_____

Birth date / / Age_____ Gender __F __M Race_____

Name of Spouse/Guardian_____ Phone_____

Address (if different than above)_____ City_____ State_____ Zip_____

Person Responsible for Payment _____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Current Medication(s) & Dosage(s)_____

Allergies_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place_____ Phone_____Hours_____

Spouse: Place_____ Phone_____Hours_____

Insurance Information

Primary Insurance_____ Secondary Insurance_____

Phone_____ Phone_____

Contract/ID#_____ Contract/ID#_____

Group/Acct#_____ Group/Acct#_____

Subscriber_____ Subscriber_____

Subscriber Date of Birth _____ Subscriber Date of Birth_____

Client's relationship to Subscriber Client's relationship to Subscriber

__Self __Spouse __Child __Other_____ __Self __Spouse __Child __Other_____

Referral Source

How did you hear of us (or from whom)?_____

Client Name: _____ **ID#** _____

PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Updated: 9/1/11

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, billing, audits, training, and continuity of care.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the timeframe, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail, we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting, it from the therapist at this location.

Complaints

If you have any complaints or questions regarding these procedures, please contact Hope for Tomorrow Mental Health Services' President & CEO Carol Watler, who will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the FL Department of Health. If you file a complaint, we will not retaliate in any way.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's Signature: _____ Date: _____/_____/_____

Parent/Guardian Signature: _____ Date: _____/_____/_____

INFORMED CONSENT TO TREATMENT

Client Name: _____ **ID#** _____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, with Hope for Tomorrow Mental Health Services, hereby referred as the Center. The rights, risks and benefits associated with the treatment have been explained to me. A qualified clinician will provide the agreed upon clinical services. I understand that the Center does employ licensed counselors as well as unlicensed counselors and interns that work under the supervision of a licensed clinician. I understand that if I am not comfortable with the qualifications of my clinician, it is my responsibility to request a re-assignment from the Center's Director or CEO.

I understand that the therapy may be discontinued at any time by either party. The Center encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge. A client may be terminated from therapy non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Center, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner, and/or C) the client does not attend or schedule an appointment for 90 days. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Center or request to re-apply for services at a later date.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center's Office(s), against any person who works for the Center, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities.

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources. Client records may be reviewed by managed care organizations including your own managed care organization, as well as the Agency for Health Care Adminstration, and/or its representatives.

I consent to treatment and agree to abide by the above stated policies and agreements with Hope for Tomorrow Mental Health Services.

_____ _____

Signature of Client Date

_____ _____

Signature of Legal Guardian *if applicable* Date

Client Name: _____ **ID#** _____

RECPIENT'S RIGHTS NOTIFICATION

As a recipient of counseling services, you should be informed of your rights as a patient. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

Your rights as a patient

1. Complaints. The Center will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services provided.
3. Civil Rights. Your civil rights are protected by federal and state laws.
4. Cultural/spiritual/gender Issues. You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, the Center will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, the Center is not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however, the Center may deny access to certain records in which this decision would be discussed with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/Legal Advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Your rights to receive information

1. Costs of services. You will be informed of how much you will be expected to pay.
2. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
3. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
4. Policy changes.

Our ethical obligations

1. This practice is dedicated to serving the best interest of each client.
2. This practice will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. This practice will maintain an objective and professional relationship with each client.
4. This practice respects the rights and views of other mental health professionals.
5. This practice will appropriately end services or refer clients to other programs when appropriate.
6. This practice will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. The Center's employees will continually attain further education and training.
7. This practice holds respect for various institutional and managerial policies but will help improve such policies if the best interest of the client is served.

Patient's responsibilities

1. You are responsible for your financial obligations to the Center as outlined in the Payment Contract for Services.
2. You are responsible for following the policies of the practice.
3. You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

What to do if you believe your rights have been violated

If you believe that your patient rights have been violated, please contact Hope President & CEO Carol Watler, in person, by telephone, or in writing at 121 S. Orange Avenue, Suite 1500, Orlando for Tomorrow Mental Health Services', FL 32801, 407-473-2813.

I consent to treatment and agree that I have read the information contained in this form and will abide by the above stated policies and agreements with Hope for Tomorrow Mental Health Services.

_____ _____

Signature of Client Date

_____ _____

Signature of Legal Guardian *if applicable* Date

PAYMENT CONTRACT FOR SERVICES

Name(s): _____

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

Bill to: Person responsible for payment of account: _____

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

Federal Truth in Lending Disclosure Statement for Professional Services:

Part One Fees for Professional Services

I (we) agree to pay Hope for Tomorrow Mental Health Services, hereafter referred to as the Center, a rate of:

$ per clinical hour (defined as 45–50 minutes for counseling) for sessions with licensed staff.

$ for the first session (defined as 60 minutes to include and assessment as well as a counseling session) with licensed staff.

A fee of $ 75 is charged for group counseling sessions.

A fee of $ 60 is charged for missed appointments or cancellations with less than 24 hours' notice.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)

This Center has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits with: _____

1) $ _____ Deductible amount (paid by insured party)
2) Co-payment/co-insurance $_____clinical unit.
3) The policy limit is _____sessions per ___annual ___calendar year.

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three All Clients

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Release of Information Authorization to Third Party

I (we) authorize Hope for Tomorrow Mental Health Services to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Hope for Tomorrow Mental Health Services .

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person responsible for account: _____ Date: ____/____/_____

Person(s) receiving services: _____ Date: ____/____/_____

Witness:_____ Date: ____/____/_____