SHERIDAN HOUSE.ORG
Answers for Today's Family

Counseling Center

Child/Adolescent Intake Form

Child's Name: _____

Address: _____ City: _____ Zip Code: _____

Date of Birth: ____/____/____ Grade: _____ School Name: _____

Presently Living With: Father ☐ Mother ☐ Relative ☐ Other Guardian ☐

Siblings (Names & Ages): _____

Religious Affiliation: _____ Active ☐ Inactive ☐

Parent Name: _____ Best Contact #: _____

May we leave a message here? Yes ☐ No ☐

Occupation: _____

Parent Name: _____ Contact #: _____

May we leave a message here? Yes ☐ No ☐

Occupation: _____

Would you like to receive e-mail notifications when your appointments Yes ☐ No ☐

are made, changed, or cancelled? If so, please provide an e-mail address: _____

Would you like to receive text message appointment reminders? Yes ☐ No ☐

If so, please provide a cell phone number and the carrier you use: _____

Would you like to be on our mailing list? Yes ☐ No ☐

Describe any physical problem that requires medication or physical care: _____

_____

Currently receiving medical treatment? Yes ☐ No ☐

Currently taking any prescription drugs? Yes ☐ No ☐

If yes, please list each drug and dosage in mgs _____

Previously attended counseling? Yes ☐ No ☐

In a sentence or two, briefly describe the *main* issue which prompted today's visit: _____

_____

_____

_____

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Privacy Notice

(Revised 10/01/2011)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, THE "PATIENT," MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Uses and Disclosures: Sheridan House Family Ministries, Inc., is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment, and health care operations. Treatment disclosures may be made to physicians and other health care providers as necessary to proceed with the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payers (*e.g.*, insurance) for the purpose of obtaining payment for services provided. Personal health information may be disclosed to carry out the daily operations such as scheduling and appointment reminders, quality reviews, audits, healthcare oversight responsibilities, accounting, and legal services. Use and disclosure of protected health information will be according to law and what is permitted and may include public health activities.

2. Required Authorizations: Unless otherwise permitted or required by law, Sheridan House Family Ministries, Inc., will not disclose any patient's personal health information for any purpose aside from what is listed in paragraph 1. without that patient's authorized consent to such disclosure. Upon request for such authorization, the patient shall have the right to refuse and/or revoke any disclosure of that patient's personal health information. The national privacy law permits disclosing personal health information to a parent or guardian of the patient; however, this information is protected for family planning services of minors, and will not be disclosed without an authorization from the patient.

3. Privacy Compliance: In accordance with the privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164 (the "Privacy Regulations"), Sheridan House Family Ministries, Inc., has adopted privacy policies regarding the use and disclosure of patients' personal health information. Sheridan House Family Ministries, Inc., is committed to complying with the Privacy Regulations and all other laws and regulations regarding patients' rights to privacy.

4. Patient's Rights: Patients have the right to access their medical records and to access an accounting of disclosures. Sheridan House Family Ministries, Inc., may, however, deny access if permitted or required by law. Patients also have the right to request amendments. Sheridan House Family Ministries, Inc. may, however, deny the amendment request under certain circumstances (for example, if it is determined that the protected health information is accurate and complete. Patients have the right to issue complaints regarding their privacy rights, or if they believe their privacy rights have been violated. Complaints must be issued in writing and may be presented to Sheridan House Family Ministries, the Department of Health or the U.S. Department of Health and Human Services. There will be no retaliation against a patient for the filing of a complaint.

5. Additional Information: For additional information regarding our privacy policy, please contact our Privacy Officer. SHFM reserves the right to change this Notice and to make the revised and changed Notice effective for medical information that we already have about a patient, as well as any information that we receive subsequently. A copy of the current Notice will be posted and a patient may also request a copy.

Patient's Signature: By my signature below, I acknowledge that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations and all of my questions about this topic have been answered and the answers are consistent with this Notice.

Signature	Printed Name	Date

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Consent for Treatment

I, _____ hereby authorize the designated agents of Sheridan House Family Ministries to provide psychotherapeutic treatment to myself, child, or family member and agree to participate in individual, group, and/or family psychotherapy/counseling sessions. Testing/assessment for psychological, social, educational, or occupational purposes may also be administered.

I understand that the information acquired as a result of these procedures will be held in the strictest confidence except when limited by provisions of Florida State Statutes (issues pertaining to suicide, child abuse, homicide, court orders, etc.) I understand that some information may be shared in professional consultation if necessary, and with managed care providers for billing purposes.

I have read this consent form and have had an opportunity to ask questions about this material and agree to the rules and guidelines herein presented. I understand that I have the right to withdraw from treatment at any time without it being held against me in any way, except that I must notify my therapist/counselor at least 24 hours in advance of the next scheduled session in order to avoid being charged for a failed session.

Note: In the case of bounced checks or insufficient funds rendered by the client to Sheridan House, Sheridan House retains the right to seek financial restitution for funds owed by the client in addition to any bank surcharges.

Should the therapist terminate services, his or her only obligation will be to provide referral to other comparable professionals in the community.

Sheridan House does not provide emergency crisis intervention. If you feel you are in a crisis situation, please call 911 or go to the nearest emergency room.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Therapist Signature Date

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Payment Agreement

Client Responsibilities:

- Payment is due at the time service is rendered. Sheridan House accepts cash, check, or credit card. If paying by check, please make it payable to Sheridan House. Please note that there will be a $25 fee charged for any returned checks. You may also pay online before your scheduled appointment at shfm.org

- In order to maintain your confidentiality, **we do not make appointment reminder calls.** You are responsible for keeping your appointments or cancelling in accordance to the policy stated below.

- Cancellations must be made at least 24 hours prior to the scheduled time of your appointment or you will be billed $50 for the missed session. The Counselor has reserved this appointment time in good faith preventing them from seeing other clients or performing other duties; therefore, cancellation fees are paid directly to the Counselor for their time.

- To cancel or reschedule your appointment, call the Counseling Center directly at (954)880-9595 at least 24 hours before your scheduled appointment.

My signature below indicates that I have read the above information carefully, understand its contents, and agree to comply with the terms of payment as stated above.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

ECFA
Enhancing Trust

SHERIDAN HOUSE .ORG

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Counseling Agreement

I, _____ & _____

understand and agree that my therapist will provide psychotherapeutic services to myself, child, and/or family member, only with the stipulation that he or she will not be called or deposed as a witness in any legal proceedings.

This includes any and all divorce proceedings, custody battles or issues, or any matter involving legal proceedings between parents or as a result of the dissolution of a marital relationship. *You are to be immune from testimony or deposition.*

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date