SHERIDAN HOUSE FAMILY MINISTRIES COUNSELING CENTER
1700 S. Flamingo Road, Davie, FL 33325 (954) 880-9595 / 1-800-838-1552/ Fax: (954) 476-3058 www.sheridanhouse.org

ADULT INTAKE FORM

Client Name:_____ Gender:_____ DOB:_____

Address:_____ City:_____ Zip Code:_____

Primary Phone:_____ May we leave a message here? ☐Yes ☐No

Primarily Living With: ☐Spouse ☐Parents ☐Children ☐Self ☐Other (specify:_____)

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone:_____

Church/Religious Affiliation:_____ ☐ Active ☐ Inactive

Highest Education Level:_____ Occupation:_____

Employed By:_____

Spouse Name:_____ Occupation:_____

Children Names & Ages:_____

Would you like to receive email notifications about your appointment? ☐Yes ☐No

If yes, please provide email address:_____

Would you like to receive text message notifications about your appointment? ☐Yes ☐No

If different number than the one above, please provide it here:_____

Will you require accommodations for physical and/or medical reasons during the sessions? ☐Yes ☐No

If yes, please explain:_____

Are you currently prescribed medication? ☐Yes ☐No

If yes, please list each medication and dosage:_____

Have you previously participated in counseling? ☐Yes ☐No

If yes, where?_____ Counselor name:_____

Please briefly describe the main issue you are seeking help for:_____

_____

_____

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PRIVACY NOTICE

(Revised 9/26/2022)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU 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. (SHFMI) is permitted by law to disclose the minimum necessary personal health information of each client 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 clients. 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, supervision, 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, SHFMI will not disclose any client's personal health information for any purpose aside from what is listed in paragraph 1 without that client's authorized consent to such disclosure. Upon request for such authorization, the client shall have the right to refuse and/or revoke any disclosure of that client's personal health information. The national privacy law permits disclosing personal health information to a parent or guardian of the client; however, this information is protected for family planning services of minors, and will not be disclosed without an authorization from the client.

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"), SHFMI has adopted privacy policies regarding the use and disclosure of clients' personal health information. SHFMI is committed to complying with the Privacy Regulations and all other laws and regulations regarding clients' rights to privacy.

4. **Clients' Rights:** Clients have the right to access their medical records and to access an accounting of disclosures. SHFMI may, however, deny access if permitted or required by law. Clients also have the right to request amendments. SHFMI may, however, deny the amendment request under certain circumstances (for example, if it is determined that the protected health information is accurate and complete). Clients 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 client for the filing of a complaint.

5. **Additional Information:** For additional information regarding our privacy policy, please contact our Privacy Officer. SHFMI 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 client, as well as any information that we receive subsequently. A copy of the current Notice will be posted and a client may also request a copy.

Client's Signature: By my signature below, I acknowledge that I have receive 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.

_____ _____

Printed Name of Client | Printed Name of Parent (if client is a minor) / Relationship to Minor

_____ _____

Client Signature (Parent Signature if client is a minor) | Date

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INFORMED CONSENT FOR TREATMENT

Please read through the following informed consent agreement. Contained in this document are the expectations for the therapist, the client, and the counseling sessions. Counseling and psychotherapy represent a unique relationship between the therapist and the client based on trust and openness, and should not be entered into lightly. Once you have read this document, and have had all questions answered to your satisfaction, please sign and date it at the end. For purposes of clarity, the terms "counselor" and "therapist" may be used interchangeably. The signor of this document (or the minor being represented) will be referred to as "client".

Services Provided The Sheridan House Counseling Center provides individual, marriage, family, and group counseling (when available). The Counseling Center is staffed by licensed professionals, and may at times also supervise registered interns who are working toward licensure, as well as student interns working toward a degree. Clients will always be made aware when an intern is involved. Services can be provided either in person or via telehealth. As licensed professionals, the counselors are able to work with mental health issues and diagnoses. In addition, counseling will be provided from a Christian perspective, and may include bible reading and prayer when appropriate. Clients have the right to inform their counselor as to the amount of spiritual emphasis they are comfortable with in their sessions. Sheridan House does not provide medical, psychiatric, or psychological testing services. Clients requiring such services will receive referrals from their counselor.

> **Sheridan House does not provide emergency crisis intervention. Clients who feel they are in a crisis situation should call 9-1-1 or go to their nearest emergency room.**

For counseling to have the greatest chance for effectiveness, the client should voluntarily agree to treatment. The client agrees to remain open and honest with the therapist, and will be receptive to feedback and instruction. The client further understands that counseling can and will often be uncomfortable. Clients and therapists both agree to participate fully in the session, and will be prepared accordingly. Because the relationship is voluntary in nature, either the therapist or the client may terminate services at any time. This may be for a variety of reasons, including lack of "therapeutic fit", conflicting schedules, or other circumstances which are prohibitive to the counseling process. Whenever possible, the therapist will provide the client with potential alternative providers.

Confidentiality Statement Sheridan House will maintain confidentiality for all clients and families seeking help. There are limits to confidentiality, as mandated by law. These limits include issues surrounding safety (abuse, self-harm, harm to others), supervision/consultation, and court-ordered release of records. All records are maintained and stored securely. All communications are compliant with regulations per the Health Insurance Portability and Accountability Act (HIPAA).

Client Responsibilities It is important that the client is on time for scheduled sessions. If a client is late, the amount of "lost time" will likely not be able to be made up, as there are often other appointments scheduled after theirs. Clients who are more than twenty (20) minutes late without any type of notice are considered a "no-show" or a failed appointment. Failed appointments may be subject to a $50 session fee, as the time was reserved in good faith, thereby making the time unavailable for other clients. Clients may cancel or reschedule their appointments, but must do so at least 24 hours prior to the appointment in order to avoid being charged for a failed appointment. Sheridan House will not call clients to remind them of their appointment due to confidentiality safeguards. However, clients may request an email and/or text confirmation of their appointment.

Financial Commitment Sessions are typically fifty (50) minutes in length. Session fees are $120 per session. Clients may pay with cash or check at the time of the session, or they may pay online through the Sheridan House website. Clients may request financial assistance either through church-sponsored sessions, or through applying for a session fee reduction based on household income. Clients who are behind in paying for sessions may be required to pay their balance before scheduling another appointment. Sheridan House does not bill directly to health insurance companies. However, clients are welcome to seek reimbursement from their insurance company if they choose.

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By my signature below, I agree to follow the conditions described in the previous page of this Informed Consent for Treatment. I further attest that I have had all my questions and concerns answered to my satisfaction, and I am willing to commit to the therapeutic process.

_____
Printed Name of Client

_____ _____
Printed Name of Parent (if client is a minor) Relationship to Minor

_____ _____
Client Signature (Parent Signature if client is a minor) Date

_____ _____
Therapist Signature Date

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FREEDOM FROM TESTIMONY AGREEMENT

We, _____ and _____
Print Client Name Print Client Name

understand and agree that our therapist will provide psychotherapeutic services (e.g., marriage counseling, family therapy, and/or individual counseling) to both/each of us and/or family members including children. This is with the stipulation that our counselor will not be called or deposed as a witness in any matter in which we are involved, either together or separately. This includes, but is not limited to, divorce proceedings, custody disputes, or other legal issues in which our counselor would be required to break confidence and provide testimony that could be detrimental to our therapeutic relationship. Our therapist is immune from being compelled to give testimony or deposition unless he/she feels it would be ethically appropriate to do so.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date