Mental Health Center of Florida

We Help You Be You. Improved.

PATIENT INFORMATION (CHILD)

CHILD NAME:______________________________DATE:______PHONE:_________________

ADDRESS:____
Street City/State Zip

AGE______________BIRTHDATE___ /___ /___________SS#______________________

REFERRED BY:_______________________MEDICAL DOCTOR:_________________________

DATE OF PREVIOUS COUNSELING:__________

MEDICATION PRESENTLY TAKING:____

FAMILY INFORMATION

PARENT OR GUARDIAN NAME:____

PHONE:____

EMAIL:____

SIBLING'S NAMES AND AGES____

NEAREST RELATIVE NOT LIVING WITH YOU_____________________________________

FAMILY INFORMATION

PARENT OR GUARDIAN NAME:____

PHONE:____

EMAIL:____

SIBLING'S NAMES AND AGES____

MHCFlorida.com

1848 SE 1st Ave. Fort Lauderdale, FL 33316 | **T** 954.885.9500 | **F** 954.885.9444

184 Treemonte Drive Orange City, FL 32763 | **T** 407.479.3050 | **F** 407.479.3052

Our Affiliates: VisitingMentalHealth.com • DrAnnMonis.com

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INSURANCE INFORMATION

☐ ChildNet ☐ Information below ☐ Self-pay

INSURANCE CO.__________________________ POLICY#___________________________

ADDRESS____

GROUP #___________________________ PHONE#__________________________________

INSURED'S NAME_________________________ RELATIONSHIP_______________________

Fees for services are to be paid at the time services are rendered unless prior arrangements are made. If unable to keep your appointment, kindly give 48 hours notice; otherwise, you will be billed for the time reserved for you.

I authorize ***MHC* of Florida** to render necessary treatment. I authorize payment of medical benefits to **MHC of Florida** for service rendered unless prior approval has been arranged. I have read and understand the above and agree to pay for all treatment rendered, including, but not limited to, all office visits and tests expenses.

____________________	____________________	__________
PARENT OR GUARDIAN'S SIGNATURE	PARENT OR GUARDIAN NAME (printed)	DATE
PARENT OR GUARDIAN'S SIGNATURE	PARENT OR GUARDIAN NAME (printed)	DATE

CANCELLATION/ OFFICE NO SHOW POLICY

Fees for services are to be paid at the time services are rendered. If unable to keep your appointment kindly give 24 hours notice; otherwise, you will be billed $15.00 for the time reserved for you.

____

Signature of Acknowledging Party

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Authorization for
Evaluation and/or Treatment

CHILD

Patient Name: ______________
Date: ______________________
Location: ___________________

1. <u>Consent to Evaluate/Treat:</u> I voluntarily consent that my child will participate in a mental health (e.g. psychological, psychiatric, and potential psychotropic medication management) evaluation and/or treatment by staff from Mental Health Center of Florida. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications, including psychotropic (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, an advanced registered nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Florida Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.

2. <u>Benefits to Evaluation/Treatment:</u> Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. <u>Charges:</u> Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. <u>Confidentiality, Harm, and Inquiry:</u> Information from my child's evaluation and/or treatment is contained in a confidential medical record at Mental Health Center of Florida, and I consent to disclosure for use by Mental Health Center of Florida staff for the purpose of continuity of my child's care. Per Florida mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. <u>Right to Withdraw Consent:</u> I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

6. <u>Expiration of Consent:</u> This consent to treat will renew every 12 months unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

______________________________	______________________________	________________	____________
Signature of responsible party or legal guardian for minor under age 18	Printed name of responsible party or legal guardian for minor under age 18	Relationship to Patient	Date
______________________________	______________________________	________________	____________
Signature of responsible party or legal guardian for minor under age 18	Printed name of responsible party or legal guardian for minor under age 18	Relationship to Patient	Date

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RELEASE OF INFORMATION

I ____, hereby give permission for Mental Health Center of Florida to share, receive, or exchange all pertinent information that will assist in the care of____________________________, as indicated below:

Check all that apply:

Get from:	Give to:	Exchange with:	**How we handle your information** (Please provide name and contact information):
☐	☐	☐	Facility: ____
☐	☐	☐	Treating Physician: _______________________________
☐	☐	☐	Supervising Physician: ____________________________
☐	☐	☐	Family: ____
☐	☐	☐	Attorney: _______________________________________
☐	☐	☐	ChildNet: _______________________________________

Other (Please provide information and explain):

____

____

_____________________________________ ___________________________

Signature Date

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

To: Any and All Treating Health Care Practitioners or Facilities:
This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164.

This document authorizes any and all licensed health care practitioners, including but not limited to: physicians, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants and other persons who have participated in providing any health care or service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, HIV, mental health, drug abuse treatment, psychiatric and psychological records, reports or information prepared by other persons that may be in your possession and all financial records, to the Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes.
This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use for licensure or disciplinary actions and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation.
By signing below, the patient understands, acknowledges and authorizes the Department to release their identity and medical records to law enforcement and other regulatory agencies in appropriate circumstances at the Department's discretion.

A photocopy of this document is as sufficient as the original.

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

Patient Name (Print):___________________________Signature: ______________________________

D.O.B.:______________________SSN:________________________ Date: ________________

Name of Authorized Person Other than Patient (Print): _______________________________________

Signature of Authorized Person Other than Patient: ____

Witness Name (Print):_________________________Witness Signature: ________________________

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Mental Health Center of Florida.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.
If you have any questions about our *Notice of Privacy Practices,* please contact our office at:

Mental Health Center of Florida
1848 SE 1st Ave. Fort Lauderdale, Florida 33316
1 (800) 771-2165 (toll free)

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address.

I acknowledge receipt of the *Notice of Privacy Practices* of Mental Health Center of Florida

Signature: ______________________________ Date: ______________________________
(patient/parent/conservator/guardian)

I acknowledge receipt of the *Notice of Privacy Practices* of Mental Health Center of Florida

Signature: ______________________________ Date: ______________________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:
Signature of provider representative: ______________________________ Date: ____________________

An acknowledgement was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because:
  ____
- ❑ There was a medical emergency (the staff member will attempt to obtain acknowledgement at the next available opportunity).

Other reason(s): ____