Oaks
Family Counseling

Patient Information Form

Client Information

First Name _____ Last Name _____

DOB _____ Age _____ Gender _____ Marital Status _____

Address _____

City _____State ____ Zip Code _____ County _____

Primary Phone _____-_____ Okay to leave message: ☐ Yes ☐ No

Cell Phone _____-_____ Okay to text: ☐ Yes ☐ No Okay to leave msg: ☐ Yes ☐ No

Email _____ Okay to Email: ☐ Yes ☐ No

Occupation _____

Detailed reasons
for treatment:

Caregiver Information (if client is a minor)

First Name _____ Last Name _____

Primary Phone _____-_____ Email _____

Relationship to client _____ Client's School _____ Grade _____

Academic Performance _____ ESE: ☐ Yes ☐ No

Behavioral Issues _____ Suspensions: ☐ Yes ☐ No

Services court ordered: ☐ Yes ☐ No Legal Charges: ☐ Yes ☐ No Probation: ☐ Yes ☐ No

Current legal charges_____

DCF Involvement: ☐ Yes ☐ No Case Manager _____

Reasons _____

Treatment History

Previous Providers _____ Last Visit _____

Reason for Treatment _____

Medical Concerns _____

Current Doctor _____ City _____

Current Medications _____

Living in your home

Name_____ Age _____ Relationship to Client _____

Name_____ Age _____ Relationship to Client _____

Name_____ Age _____ Relationship to Client _____

Name_____ Age _____ Relationship to Client _____

Name_____ Age _____ Relationship to Client _____

Name_____ Age _____ Relationship to Client _____

Recent Symptoms

- ☐ Anxiety
- ☐ Fearful
- ☐ Nervousness
- ☐ Mood Swings
- ☐ Depression
- ☐ Stress
- ☐ Abuse
- ☐ Family Stress
- ☐ Divorce/Break Up
- ☐ Family Death/Loss
- ☐ Self-Harm (cutting, etc)
- ☐ Suicidal Behavior/Attempt
- ☐ Recent Move
- ☐ Shyness
- ☐ Nightmares
- ☐ Flashbacks/Bad Memories
- ☐ Dizziness
- ☐ Headaches
- ☐ Sleep Problems
- ☐ Eating Issues
- ☐ Bathroom Issues
- ☐ Sexually Related Issues
- ☐ Legal Issues
- ☐ School/Work Issues
- ☐ Drug/Alcohol Issues
- ☐ Parenting Issues
- ☐ Hyperactive
- ☐ Impulsive
- ☐ Unable to Focus
- ☐ Argumentative
- ☐ Anger
- ☐ Self-Control Issues
- ☐ Unmotivated
- ☐ Temper/Outbursts
- ☐ Lying
- ☐ Stealing
- ☐ Destructive
- ☐ Recent Arrest
- ☐ Family Arrest/Jailed

Treatment Goals

Emergency Contact Person & Financially Responsible Party

Emergency Contact _____ Phone Number _____

Financially Responsible Party _____

Additional Information

How did you hear about us? _____

Signature

Signature of Client _____ Date _____

Signature of Parent/Guardian (if minor) _____ Date _____

Oaks
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Consent for Treatment, Assessment and/or Evaluation

Client Name _____ DOB _____

Regarding services at Oaks Family Counseling I understand that:

- My participation in any/all services is voluntary and that my consent and/or participation may be withdrawn at my discretion.
- If there is a court order for me, or my child to participate in treatment, my participation is still voluntary.
- I have the right to understand the purpose and goals of my treatment and can ask questions at any time.
- My confidentiality will be protected at all times and personal information will not be released without my permission.
- There are legal limitations on confidentiality that must be observed by all mental health professionals. Specifically, Oaks Family Counseling has a legal responsibility for assessing risks associated with suicidal and/or homicidal ideation and depending on the risk Oaks Family Counseling has a duty to protect the client and/or others who might be in harm's way. This may include helping a client attain a safe environment by assisting with emergency mental health services, calling 911 and/or contacting law enforcement.
- Services will be provided within the scope of my specific provider's licensure, certification, and training. I will be informed in the event that my mental health needs are beyond the scope and practice of my provider's qualifications.
- Counseling and behavioral health treatment is not an exact science and active and appropriate participation is necessary for best results. No specific treatment recommendations and/or outcomes can be promised or guaranteed.
- Oaks Family Counseling does not provide emergency or afterhours services and I should contact a crisis line, 911, mental health facility and/or hospital in a life threatening and/or emergency situation.
- My services may be discontinued at the discretion of Oaks Family Counseling if I am inappropriate, destructive or unlawful and if I do not participate appropriately or do not attend scheduled appointments.
- I may have a copy of this form as well as the HIPAA Notice of Privacy Practices and Patient's Rights at any time by request.

I, as the client, or as the parent/legal guardian of the client named above, agree with all of the conditions above and grant Oaks Family Counseling permission to assess, evaluate, and/or treat the client named above.

Signature of Client _____ Date _____

Signature of Parent/Guardian (if minor) _____ Date _____

HIPAA Notice of Privacy Practices and Patient's Rights

Client Name _____ DOB _____

This notice provides you with information about how your mental health records at Oaks Family Counseling may be used, the rights you have as a client, and our legal duties as providers of treatment. We are required to provide you with this notice under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. This law is designed to protect the confidentiality of your treatment records. Your medical records are used to provide treatment, bill and receive payments, and conduct our healthcare operations. You will be provided with a copy of this form and asked to sign an agreement during your first session with Oaks Family Counseling. If you do not agree to the information provided in this notice, we cannot treat you.

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully. Please let us know if you have any questions or would like additional information.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, texts or emails, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal representative.
2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure puts you at risk of harm.
3. Disclosed information will be limited to the minimum necessary. You may request a list for any use or disclosures other than those described in Sections 1 and Sections 2.
4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site.
5. You may request corrections to your records.
6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information

references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.
8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.
9. If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns/questions about your privacy rights, you may speak with your counselor privately about any of your concerns. If you believe that your privacy rights have been violated and wish to file a complaint, you may request a Client Compliant Form from your counselor. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule. Oaks Family Counseling will not retaliate against you for exercising your right to file a complaint.
10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION. THIS ACKNOWLEDGEMENT WILL BECOME PART OF YOUR RECORDS.

Signature of Client _____ Date _____

Signature of Parent/Guardian (if minor) _____ Date _____

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Comprehensive Authorization to Release/Receive Information

Client Name _____ DOB _____

This authorizes Oaks Family Counseling to release and/or receive general medical, psychiatric/psychological, assessment and/or school information from my client records in accordance with Florida Statues and Federal Administrative Rules and Regulations. Oaks Family Practice is released from any legal liability that may arise from the release/receipt of the information requested.

Agencies and parties to and from authorization pertain: (Please mark all boxes that apply)

- ☐ Department of Children and Families (DCF)
- ☐ Department of Juvenile Justice (DJJ)
- ☐ Guardian ad Litem Program (GAL)
- ☐ Meridian Behavioral Healthcare, Inc.
- ☐ Alachua County School Board
- ☐ Public Defender's Office
- ☐ Office of the State Attorney
- ☐ UF Health/Shands Providers
- ☐ Mental Health Providers: _____
- ☐ Medical Providers: _____
- ☐ Schools: _____ County _____
- ☐ Extended Family Members: _____
- ☐ Non-Relative Placement: _____
- ☐ Foster Parents: _____
- ☐ Others (Please list): _____

Information to be released is as follows: (Please mark all boxes that apply)

- ☐ History, Physical, Lab Work
- ☐ Legal/Court Records
- ☐ Psychiatric/Psychological Reports
- ☐ Substance Abuse Records
- ☐ Education and School Records
- ☐ Behavioral Records
- ☐ Treatment Records
- ☐ Social History

This authorization will be valid for one year from the date specified below or until the client identified above is discharged from treatment, whichever is latest. I understand that I have the right to terminate this authorization at any time by sending a written statement indicating such to Oaks Family Counseling, except to the extent that action has already been taken in accordance with the above authorization. This authorization will be valid for all methods of communication (phone, fax, mail, email).

Signature of Client or Parent/Guardian _____ Date _____

Witness Signature _____ Witness Name _____Date _____

Oaks Family Counseling

Fee Agreement

Client Name _____ DOB _____

Fees

Fees are based on the services provided. A Sliding Scale/Discounted fee may be available for clients who meet specified criteria. If you wish to explore this possibility, please speak directly with your counselor. You may be required to provide proof of income (ex. Tax Return, paystub) in order to receive a discounted fee.

Payments

Full payment is expected at the time of service. Oaks Family Counseling accepts cash, credit cards and debit cards. Failure to pay for services may result is your services being suspended and/or late fees until your account is paid in full. If the decision is made to submit your account to a collection agency, you will be responsible for any attorney and/or other fees incurred in collecting your overdue balance.

Cancellations and/or Missed Appointments

If you are unable to keep your scheduled appointment, please contact your counselor directly at least 24 hours before your appointment time. If you fail to cancel your appointment at least 24 hours in advance you will be charged the full fee for the missed session. Clients who cancel and/or miss three (3) or more sessions may be discharged from treatment.

Signature of Client _____ Date _____

Signature of Parent/Guardian (if minor) _____ Date _____

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Credit / Debit Card Payment Consent Form

Client Name: _____ **DOB:** _____

Name on Card if different than client: _____

I authorize *Oaks Family Counseling* to charge my credit or debit card for counseling or related services 24 hours before the scheduled appointment. If I do not cancel before 24 hours, I recognize that *Oaks Family Counseling* will charge my card as a late cancel or as a no show if I do not show up for the appointment. I will be billed for the full session charge of $_____ per 50 minute session or $_____ per 75 minute session.

I verify that my credit or debit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within fifteen (15) days.

Signature: _____ Date: _____