COMPASS COUNSELING SERVICES
1400 North Semoran Boulevard Suite E, Orlando, FL 32807 | Phone: (407) 823 - 8421 | Fax: (407) 823 – 8195

Youth Intake Form: Client and Parent Information

Today's Date: _____/_____/_____ **Date of Birth:** _____/_____/_____ **Age:** _____

Youth Name: _____ **Preferred Name:** _____
First Middle Last

Social Security Number: _____ **Gender:** _____ **Current Grade:** _____
(may be needed for insurance)

Address: _____
Street Address Apartment/Unit # City State ZIP Code

****CCS will NOT list personal cell phone numbers and emails of youth/minors as a primary form of contact.****

Race and Ethnicity (check all that apply): ☐ Asian/Pacific Islander ☐ African-American/Black ☐ Latino/Hispanic ☐ Native American ☐ White/Caucasian ☐ Decline to Specify

Child's Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
****CCS will follow legal custody parenting agreement. If both parents share custody and medical decision making, then both parents must agree to treatment. *CCS may also ask legal guardians for proof of documentation.**

1) Parent/Guardian Name: _____ **Date of Birth:** ____/____/_____
First Last

- **Relationship to youth:** ☐ Mother ☐ Father ☐ Grandparent ☐ Other: _____
- **Have legal custody?:** ☐ Yes ☐ No **Lives with the youth?:** ☐ Yes ☐ No
- **Parent's primary language?:** ☐ English ☐ Spanish ☐ Other: _____
  ****CCS Provider will be assigned to the youth/family based on parent's primary language.**

Cell/Mobile: (_____) _____ - _____ **Send a text?** ☐Yes ☐No **Leave voicemail?** ☐Yes ☐No

Home or Work: (_____) _____ - _____ **May we leave a voicemail here?** ☐ Yes ☐ No

Parent E-mail: _____
****CCS has an online "Patient Portal" and to access your portal, an e-mail address is required. Please note that parents who are seeking services at CCS and/or have other children seeking services at CCS, a different e-mail address is required for each portal.**

2) Parent/Guardian Name: _____ **Date of Birth:** ____/____/_____
First Last

- **Relationship to youth:** ☐ Mother ☐ Father ☐ Grandparent ☐ Other: _____
- **Have legal custody?** ☐ Yes ☐ No **Lives with the youth?** ☐ Yes ☐ No

Cell/Mobile: (_____) _____ - _____ **Send a text?** ☐Yes ☐ No **Leave voicemail?** ☐Yes ☐No
Home or Work: (_____) _____ - _____ **May we leave a voicemail here?** ☐ Yes ☐ No

Emergency Contact: _____ **Phone: (_____) _____ - _____**
Relationship to youth: _____ **Lives with the youth?** ☐ Yes ☐ No

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Primary Insurance Holder Information *(Please fully complete this section.)*

Policy Holder Name (as written on card!): _____

Primary Health Insurance Company: _____

Member/ID Number: _____ **Relationship to Client:** ☐ **Child/Self** ☐ **Parent**

Secondary Health Insurance Company: _____

Member/ID Number: _____ **Relationship to Client:** ☐ **Child/Self** ☐ **Parent**

Service Payment & Assignment of Health Care Benefits

Client Acknowledgement

I, **(parent/guardian name)** _____**, parent/guardian of (youth name)**

_____**(date of birth:**_____**),** certify that the information stated above is true and accurate to the best of my knowledge. I hereby authorize Compass Counseling Services, LLC (CCS), to bill me, my health insurance company, and or my representative for all services that I receive. I further authorize my health insurance company or its representative to make direct payment of benefits to CCS or its providers under the terms and conditions of my health care contract. It is my responsibility to understand my coverage, including co-pays, co-insurance, and deductibles. This also includes understanding what services are covered or not. It is also my responsibility to let CCS know if there is a change in my insurance or coverage.

I understand that I am ultimately responsible for payment of all services. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child**. I will be held liable for any care provided to me, or to the client for whom I am legally responsible for, even when not covered by the insurance company. I agree to all payments, including co-pays, co-insurances, specimen collection, and deductibles. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.**

In addition, I authorize the appropriate staff at CCS to fill out any and all necessary paperwork or electronic claims required by my insurance carrier or managed care company, including but not limited to: treatment plans, insurance claim forms and termination of care information. I affirm that I have read, understand, and agree to the authorizations stated above.

_____ _____

SIGNATURE OF CLIENT'S PARENT/GUARDIAN **TODAY'S DATE**

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Primary Care Physician/Pediatrician *(Required Information.)*

Medical Doctor Name: _____

Office/Group Name: _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____

Address: _____
Street Address Suite/Unit # City State ZIP Code

Pharmacy *(Required if interested in medication management.)*

Pharmacy Name: _____ **Phone:** (_____) _____ - _____

Address: _____
Street Address Suite/Unit # City State ZIP Code

Medical Cannabis/Marijuana Use Card: ☐ Yes ☐ No **Patient ID #:** _____
***CCS clients with prescribed marijuana should disclose to CCS medical provider and provide copy of card.**

Mental Health Information

How did you learn of CCS?: _____ **I prefer this CCS office:** ☐ Orlando **OR** ☐ Kissimmee

Which services are you interested in? A provider may recommend additional services for your treatment.
☐ Psychiatric Evaluation ☐ Psychiatric Medication Management ☐ Individual Therapy ☐ Family Therapy

☐ Couples Therapy ☐ Group Therapy ☐ Psycho-Social Rehabilitation (PSR) Services ☐ Other (specify): _____

What concerns or problem are you are seeking help for?: _____

Has your child previously received counseling/psychotherapy services? ☐ **Yes** ☐ **No**
Has your child previously taken psychiatric medications? ☐ **Yes** ☐ **No**

Has your child previously been hospitalized for psychiatric/mental health reasons? ☐ **Yes** ☐ **No**

Approximate Date	Length of Stay	Hospital	Reason for Admission

Current psychiatric/mental health medications: _____
Does your child have a disability or impairment that requires accommodations in the office? ☐ **Yes** ☐ **No**
Please identify accommodations: _____

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Authorization to Obtain/Release Protected Mental Health Information: Primary Care Physician/Doctor

This is an authorization for Compass Counseling Services, LLC (CCS) to release, obtain, and/or exchange protected mental health information with your primary care physician/medical doctor for the purposes of coordinating medical care and treatment. By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the provider/agency listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Client Name: _____ **Client Date of Birth:** _____/_____/_____

1. PLEASE CHECK:

☐ I hereby **REFUSE** to give CCS authorization to release any treatment information to my primary care physician (PCP) at this time.

☐ I **AUTHORIZE** CCS **to receive and obtain** information from my primary care physician, in addition **to release a copy of the initial visit record to my doctor/physician and/or release copies of my visit notes when requested by physician.**

2. Primary Care Physician/Doctor Name:_____

Group/Office Name: _____

Address:_____

Phone Number: _____ **Fax Number:** _____

3. TYPE OF INFORMATION TO BE DISCLOSED:

This authorization does not represent a complete medical records access request. For a primary care physician/doctor to access the full record, a separate authorization will need to be completed.

4. Note any exclusions or limitations here: _____

I certify that my health information is being disclosed at my request or at the request of my personal representative. I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given CCS/my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. I am also aware that utilizing my health and or my mental health records for legal purposes are left up to the interpretation by legal representatives and may or may not be beneficial to my legal case. This authorization **will expire one year** following the date signed unless revoked in writing.

_____	_____	_____
PRINT CLIENT'S NAME	**SIGNATURE OF CLIENT**	**TODAY'S DATE**
_____	_____	_____
PRINT NAME OF LEGAL GUARDIAN OR REPRESENTATIVE	**SIGNATURE OF LEGAL GUARDIAN OR REPRESENTATIVE**	**TODAY'S DATE**

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Authorization for Family Member/Personal Representative

I authorize the person(s) (adults age 18 and over) identified below to communicate with Compass Counseling Services, LLC (CCS) in regards to my health care information for specific purposes.

NAME	PHONE	RELATIONSHIP TO PATIENT

I authorize this person to *(please check all that apply)*: ☐ **ALL PURPOSES LISTED HERE**

☐ **Create/Cancel Appointments** ☐ **Pick Up Medical Records** ☐ **Pick Up Forms/Letters**

☐ **Discuss Billing Information** ☐ **Participate in Sessions** ☐ **Pick Up Prescriptions in Office**

NAME	PHONE	RELATIONSHIP TO PATIENT

I authorize this person to *(please check all that apply)*: ☐ **ALL PURPOSES LISTED HERE**

☐ **Create/Cancel Appointments** ☐ **Pick Up Medical Records** ☐ **Pick Up Forms/Letters**

☐ **Discuss Billing Information** ☐ **Participate in Sessions** ☐ **Pick Up Prescriptions in Office**

NAME	PHONE	RELATIONSHIP TO PATIENT

I authorize this person to *(please check all that apply)*: ☐ **ALL PURPOSES LISTED HERE**

☐ **Create/Cancel Appointments** ☐ **Pick Up Medical Records** ☐ **Pick Up Forms/Letters**

☐ **Discuss Billing Information** ☐ **Participate in Sessions** ☐ **Pick up Prescriptions in Office**

My signature below represents that I understand this form is valid for <u>one year</u> from date of signature and may be revoked by me (or my legal representative) at any time in writing to CCS. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services or eligibility for benefits. Additionally, I understand that a separate Authorization is needed if I want to give someone full access to my health record.

_____ _____ _____ _____

PRINT CLIENT'S NAME | **DATE OF BIRTH** | **SIGNATURE OF CLIENT** | **TODAY'S DATE**

_____ _____ _____

PRINT NAME OF LEGAL GUARDIAN OR REPRESENTATIVE | **SIGNATURE OF LEGAL GUARDIAN OR REPRESENTATIVE** | **TODAY'S DATE**

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Youth Intake Form: Acknowledgement of Receipt of the Client Handbook

This page is an **Acknowledgment of Receipt of the Client Handbook** which outlines expectations, policies, and practices regarding CCS services. The Client Handbook provided for you is to review and keep. The Client Handbook includes but is not limited to: client/patient rights and responsibilities, process of treatment services, risks and benefits of mental health treatment, privacy policies, treatment options and medical necessity, urine drug screening (UDS) policy, fees and service costs, minors and custody issues, health and safety, emergency and crisis resources. Please **complete and sign this Acknowledgement** page to confirm that you have received a copy of the Client Handbook prior to the start of treatment.

Your initials below indicate your understanding and agreement to these policies and practices written below and the Client Handbook.

Initials: **Please write your initials on the lines to show your agreement and understanding:**

- _____ I acknowledge that **I have received and reviewed my copy of the Client Handbook** and any questions have been answered. I know that printed and electronic versions are available at my request.
- _____ I have reviewed and understand the **Client/Patient Rights and Responsibilities** for services at CCS. This includes complaints, fees, no-show/cancellation policies, and my rights.
- _____ I have reviewed and understand the expectations and policies related to CCS service costs and fees. If I cancel within **24 hours or do not show** for an appointment, **I will pay $25** (not billed to insurance). I am responsible for payment of co-pays, co-insurance, deductibles, and fees not covered by my plan.
- _____ I have reviewed and understand the **Informed Consent for Assessment & Treatment Form**. I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment, or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. I understand the risks and benefits of mental health treatment.
- _____ I have reviewed and understand the Informed Consent for **Telehealth Services.** I certify that If services are online/virtual, I consent to this and understand any risks that may be associated with this service. **I also agree to remain in the state of Florida during my virtual appointment with my CCS provider** (who is licensed/registered for services in FL).
- _____ I acknowledge receipt of the **Notice of Privacy Practices**, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service. I understand that CCS will share basic information with my primary care provider unless I ask to "restrict" this disclosure. This includes privacy and exceptions to confidentiality. Any questions I have regarding these practices have been answered.
- _____ I have reviewed and understand the **Urine Drug Screening (UDS) Policy** at CCS. If it is determined by a provider that a minor may benefit from a screening, a new consent form will be provided to the parent/guardian.
- _____ I have reviewed and understand **CCS expectations and response to client crisis situations**. I understand that my CCS provider may not be available to provide me with immediate support. I have received crisis resources that I may contact.

PRINT CLIENT'S NAME	DATE OF BIRTH	SIGNATURE OF CLIENT	TODAY'S DATE
_____	_____	_____	_____

PRINT NAME OF LEGAL GUARDIAN OR REPRESENTATIVE	SIGNATURE OF LEGAL GUARDIAN OR REPRESENTATIVE	TODAY'S DATE
_____	_____	_____