Orlando Office
1400 North Semoran Blvd Orlando, Suite E. FL 32807
Phone: (407) 823 - 8421 / Fax: (407) 823 - 8195

Kissimmee Office
201 Ruby Avenue, Suite B Kissimmee, FL 34741
Phone: (407) 933 - 1847 / Fax: (407) 933 - 1849

Youth Intake Form: Client 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

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

Parents Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent/Guardian Name: ____ **Date of Birth:** ____/____/______
First Middle Last

Does this person have legal custody? ☐ **Yes** ☐ **No** **(CCS may ask legal guardians for proof of documentation.)**

Live with the youth? ☐ **Yes** ☐ **No** **Relationship to youth:** ☐ **Mother** ☐ **Father** ☐ **Grandparent** ☐ **Other:**_______________

Cell/Mobile: (_______) _________ - _____________ **May we send a text?** ☐ **Yes** ☐ **No** **Leave voicemail?** ☐ **Yes** ☐ **No**
Home or Work: (_______) _________ - _____________ **May we leave a voicemail here?** ☐ **Yes** ☐ **No**

Parent/Guardian Name: ____ **Date of Birth:** ____/____/______
First Middle Last

Legal custody? ☐ **Yes** ☐ **No** **Live with the youth?** ☐ **Yes** ☐ **No** **OK to share appt. info. with?** ☐ **Yes** ☐ **No**

Cell/Mobile: (_______) _________ - _____________ **May we send a text?** ☐ **Yes** ☐ **No** **Leave voicemail?** ☐ **Yes** ☐ **No**
Home or Work: (_______) _________ - _____________ **May we leave a voicemail here?** ☐ **Yes** ☐ **No**

Emergency Contact: _________________________________ **This person lives with the client?** ☐ **Yes** ☐ **No**
Phone: (_______) _________ - _____________ **Relationship to youth:** __________________________

Compass Counseling Services, LLC has a "Patient Portal" that gives you the ability to see appointments, request changes, view statements, and access medical information. To access this portal, please provide parent/guardian email address:

____@____

Pediatrician/Primary Care Provider *(Required Information)*

Primary Care Provider Name: _____________________________ **PCP Group (if applicable):** ____________________

PCP Phone: (_______) __________ - ____________ **Fax: (_______) ________ - ____________**

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

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Pharmacy *(if interested in medication management)* & Former Psychiatrist

Preferred Pharmacy: ___________________________________ **Phone: (_______) ________ - _____________**

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

Psychiatrist (current or former): ____________________________ **Phone: (_______) ________ - ____________**

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

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

Primary Health Insurance Company: ___________________________ **Policy number:** ____________________
Subscriber Name: ____________________________ **Client's Relationship to Subscriber:** ☐ **Self** ☐ **Parent**

Employer (for Group Plan): ____

(Secondary) Health Insurance: ____________________________ **Policy number:** ______________________
Subscriber Name: ____________________________ **Client's Relationship to Subscriber:** ☐ **Self** ☐ **Parent**

Health Insurance Information & Assignment of Health Care Benefits

Client Acknowledgement

I, **(parent/guardian name)** _____________________, **parent/guardian of (youth name)** _________________, 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 my health insurance company or its 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.

In accordance with my health care contract, 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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Referral Source

How did you learn of CCS? ☐ Primary Care Physician (PCP) ☐ Insurance Company ☐ DCF ☐ DOJ ☐ Friend

☐ School/Teacher ☐ Previous Therapist ☐ Previous Psychiatrist ☐ CCS Website ☐ Other:____________

Referral Name: ______________________________________ **Phone: (_______) ________ - ____________**

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

☐ **Yes** ☐ **No** **I will complete an Authorization of Release so that CCS can obtain, release, and exchange my treatment information with my referral source.**

Explanation of Records Release of Authorization for the Release of Protected Mental Health Information

For CCS to release, obtain, and or discuss your private health information (PHI) with another provider, people, or agencies you may be affiliated with, you must sign a **Records Release of Authorization**. On the next page, you will be asked to authorize or refuse authorization for any release of information pertaining to your mental health treatment at CCS.

A separate **Records Release of Authorization** form is required for **each** individual/provider/entity/agency for which you decide to grant authorization to release, obtain, and/or exchange information regarding your CCS mental health records. You may decide what parts of your records you want to release. This form **will expire one year following the date signed unless revoked in writing.**

Common entities/people/agencies to which parents provide authorization include but are not limited to the child's primary care physician (PCP)**, referral source, school, employer, previous mental health providers (therapist or psychiatrist), community agency, government agency, lawyer, etc.

****CCS encourages all CCS clients to provide an authorization to their Primary Care Physician to coordinate care.** CCS will share basic information (such as confirming that you are a CCS client) with your primary care provider unless a client asks to "restrict" this disclosure. Please consider using the next page to authorize your primary care physician.

For additional Authorization forms, please ask the Front Desk staff or download an additional copy from the CCS website or the "Patient Portal." To request specific mental health records from CCS, please consult Front Desk staff to obtain a **Request of Documentation Form.** All requests will take a minimum of 7-10 business days to be completed. There may be a fee for the requested documentation, and clients are expected to pay all associated fees before receiving the requested documentation.

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Records Release of Authorization for the Release of Protected Mental Health Information

This is a records release of authorization for Compass Counseling Services, LLC (CCS) to release, obtain, and/or exchange of protected mental health information. By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies 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 for any release of information, including my primary care physician (PCP), at this time.

☐ I authorize my **CCS provider/CCS** to ☐ **RELEASE** ☐**AND RECEIVE** psychological/psychiatric mental health information to/from the SECOND PARTY as directed below:

2. SECOND PARTY:

Name: ____

Address:____

Fax Number: ____ **Phone Number:** ______________________________________

3. TYPE OF INFORMATION TO BE DISCLOSED:

☐ I authorize disclosure of **ALL** health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy.

☐ I authorize **ONLY** the disclosure of the following information: ☐ **Client Confirmation Letter** ☐ **Counseling Assessment with Treatment Plan** ☐ **Counseling Discharge Summary** ☐ **Psychiatric Evaluation/Assessment with Treatment Plan** ☐ **List of Psychiatric Medications** ☐ **Laboratory/Diagnostic Test Results** ☐ **Medication Progress Notes** ☐ **Psychological Evaluation/Testing Results from CCS** ☐ **Substance Abuse Treatment Record** ☐ **Other (specify):** ____

4. PURPOSE: ☐ **Insurance/Payment** ☐ **Personal Use** ☐ **Participation in Sessions** ☐ **Legal Action** ☐ **Client Communication/Coordination of Care** ☐ **Treatment Information** ☐ **Continued Treatment** ☐ **Appointment Coordination** ☐ **Other (specify):** ____

5. 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. This authorization **will expire one year** following the date signed unless revoked in writing.

I understand that a request for documentation will take minimum of 7-10 business days to be completed. I understand that there may be a fee for the requested documentation, and I agree to pay all associated fees before receiving the requested documentation. (Please consult office staff to determine associated fees). I also understand that the request for documentation may contain personal and sensitive information, and I agree to the release of this information as requested.

I am 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.

___________________________________	___________________________________	____________________
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

☐ **Authorization is given on this patient's behalf due to being a minor or unable to sign.**

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Youth Intake Form: Mental Health Information

Who is completing this form? ☐ Youth **Or** ☐ Parent/Guardian **Or** ☐ Both Youth and Parent/Guardian

Please describe the concerns or problem that brought you here today: ____

____

When did you first notice this problem?: ____

Describe any treatment you have tried to address this problem and/or other problems:

	When? (Start – Finish)	Where?	Why?
Outpatient therapy/ counseling			
Medication (mental health)			
Psychiatric hospitalization			
Drug/alcohol treatment			
Self-help/support groups			
Other (specify):			

What is your goal for therapy?____

Which type of services below would you consider while working with CCS providers for these concerns? Services will be offered based on medical necessity in collaboration with your provider. ☐ Individual Therapy ☐ Family Therapy ☐ Couples Therapy ☐ Group Therapy ☐ Psychiatric Evaluation ☐ Psychiatric Medication Management ☐ Psycho-Social Rehabilitation (PSR) Services ☐ Other (specify): ___________________________________

I prefer a provider who speaks: ☐ English ☐ Spanish ☐ No preference ☐ Other: ____________

I prefer this CCS location: ☐ Orlando **OR** ☐ Kissimmee **I am able to use stairs?:** ☐Yes ☐ No

To get to CCS office for services, I will (check all that apply): ☐ use my own vehicle ☐ use public transportation ☐ use MediCab ☐ use Uber/Lyft/Other ☐ ask family member/friend would provide ☐ walk ☐ ride bicycle

Youth and or/parent has a physical disability or impairment and needs the following accommodations:______________

____

Other information that you think we should know about you:____

In general, days/times that I'm available for appointments are:____

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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 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 agree to stay on CCS premises for the youth's in-person sessions.**
- __________ 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**. 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 agree to stay with the client in the state of Florida, in the same physical location as client, during virtual sessions.**
- __________ 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.
- __________ 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.

Print Client's Name: ____ **Client's Date of Birth:** ___________________

____ ____ ____________________
Print Name of Parent/Legal Guardian **Signature of Parent/Legal Guardian** **Today's Date**