Receipt of Client Handbook Acknowledgement

Client Name:	Client D.O.B
Legal Guardian Name:	**Relationship to Client**

By signing below, I am acknowledging that I received a Client Handbook which I was oriented to and includes information about:

- Families Connect Hours of Operation;
- A description of the services to be provided;
- Client safety;
- Notice of Privacy Practices;
- Basic HIV/AIDS Education
- Contact Information;
- Applicable fees, if any;
- Information on client rights and responsibilities including rules;
- Client satisfaction and grievance procedures.
- General information regarding infection control policies and procedures

I understand that I can contact Families Connect with any questions or input and can request additional information at any time if needed.

Financial Acknowledgement

I have read and understand the financial policy as described in the Client Handbook. I agree to pay, promptly and in full, any amounts due, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

Consent for Treatment

I hereby authorize Families Connect, in accordance with the client's treatment plan to provide assessments, Parent Child Interaction Therapy (PCIT) and any necessary treatment to include targeted case management services, to the above-named client in accordance with the program guidelines and requirements subject to the limitations set forth in Florida Statutes including telemedicine services.

In addition, I authorize Families Connect to audiotape/videotape sessions of the above-named client for training purposes and I have been informed and understand the following:

- I can request that the audio recorder and/or video recorder be turned off at any time and may request that the recording or any portion thereof be erased. I may terminate this permission to record at any time.
- The contents of these recorded sessions are confidential, and the information will not be shared outside the context of individual and group supervision/instruction.
- The recordings will be stored in a secure location and will not be used for any other purpose without my explicit written permission and the recordings will be erased immediately after supervision and/or instruction has been completed.

By signing below, I attest that I have been given information regarding, and understand, the reason for admission, diagnosis, and planned course of treatment, alternatives, risks, and prognosis.

I am providing this consent to treatment voluntarily and understand that I have the right to withdraw from treatment at any time either orally or in writing.

Client Signature | Signature Date

Legal Guardian Signature | Signature Date

Telephone Number *(813) 813-295-8383*
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