|  |
| --- |
| (Please Print) |
| Today’s date: | Client Number: |
| CLIENT INFORMATION |
| Client’s last name: | First: | Middle: | ❑ Mr.❑ Mrs.❑ Dr. | ❑ Miss❑ Ms. | Marital status (circle one) |
| [*client name*] | Single / Mar / Div / Sep / Wid |
| Primary Language | Race: | Ethnicity | Birth date: | Age: | Sex: |
|  |  |  |  / / |  | ❑ M | ❑ F |
| Street address: | Home phone no.: | Cell phone no.: |
|  | ( ) | ( ) |
| P.O. box: | City: | State: | ZIP Code: |
|  |  |  |  |
|  |  |  |  |
| Occupation: | Employer / School: | Highest Grade completed: |
|  |  |  |
| Chose clinic because/Referred to agency by (please check one box): | ❑ Dr. |  | ❑ Insurance Plan | ❑ Hospital |
| ❑ Family | ❑ Friend | ❑ Close to home/work | ❑ Yellow Pages | ❑ Other |  |
| Reason for Referral? |  |
|  |
| Additional INFORMATION |
| Legal Guardian Name: | Relationship to client: | Address (if different): | phone no.: |
|  |  |  | ( ) |
|  | DCF involvement? | Caseworker Name: | Caseworker phone no.: |
|  | ❑ Yes ❑ No |  | ( ) |
| Any pets in the home?  | Legal Involvement?❑ Yes ❑ No | Probation officer Name: | Probation phone no.: |
| ❑ No ❑ Yes: \_\_\_\_\_\_\_\_\_\_\_  |  | ( ) |
| Any other current or recent providers for Mental Health, Behavioral Health, or Substance Treatment?  |
| IN CASE OF EMERGENCY |
| Name of Local Friend or Relative you’d like us to contact in case of emergency: | Relationship to client: | Home phone no.: | Work phone no.: |
|  |  | ( ) | ( ) |
| Financial agreement |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the agency. I understand that I am financially responsible for, and agree to pay, any balance or co-payments on my account. I also authorize Psychamerica Behavioral Services LLC/Big Bear Behavioral Health Inc or my insurance company to release any information required to process my claims. If I lose, or choose not to use my insurance, my Self-Pay rate for individual therapy is $\_\_\_\_\_\_\_\_ per hour, due at time of service. If I choose to self pay, a further breakdown of fees for services will be made available. |

# Demographic FORM

## CONSENT & AGREEMENT FOR SERVICES

**AUTHORITY TO CONSENT**: I certify that I have the legal authority to consent to treatment, medication, release of information, and all legal issues involving the above-named client. If my status as legal guardian should change, I will Immediately notify the agency of the name, address, and telephone number of the person who has assumed guardianship of the above-named client. I consent for the above-named client to participate in mental health assessment, treatment through Big Bear Behavioral. I understand that I may revoke consent for the above at any time; however, I cannot revoke consent for action that has already been taken.

**For guardians other than biological or Adoptive parents**:

My relationship to client is: **AND** I have provided the following legally binding documentation to demonstrate authority to consent:

 Notarized Power of Attorney Shelter Order Other:

 **ATTENDANCE / EMERGENCIES**:

I agree to notify my assigned clinician at least 24 hours in advance if I will not be able to keep my scheduled appointment (leave a voicemail, text message, or send an e-mail). I understand my clinician may close my case if I have 3+ no-shows/ cancellations within a two-month period.

I understand that in case of mental health emergencies, I must call 911 or another appropriate source. I understand that my clinician might not be available at the time of an emergency. If an emergency occurs, after calling 911 or the appropriate phone number, I will notify my clinician alerting him/her of the situation. I understand that a list of emergency phone numbers and community resource phone numbers can be found online at [www.bigbearcounseling.org](http://www.bigbearcounseling.org) / I understand that I was given a handbook with emergency phone numbers I may use.

**CONSENT LOCATION** - I authorize and give consent for the above named individual to participate in mental health and behavioral health services and treatment through Psychamerica/Big Bear at the following locations:

 Home School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that receiving services at school requires information to be shared with the school staff (as indicated on Release of Information for the school), and the security and confidentiality concerns inherent in school based services have been explained to me.

**DISCHARGE/AFTERCARE PLAN –** If you ever unexpectedly lose funding, I elect the following:

[\_\_] Pay for services on my own, day of service at the Self-Pay Rate.

[\_\_] Have my case closed and receive referrals for alternative community resources

[\_\_] Place services on hold for a month while I contact my insurance company to have funding reinstated

**Client Handbook–** I have been provided a copy of the Big Bear Behavioral Health, Inc **client handbook**, and each section has been explained to me to my satisfaction; including but not limited to Rights & Responsibilities, Privacy & Practices, Confidentiality, and the Grievance Procedure.

**By Signing below, I acknowledge**: that the information on this page has been explained to me. I understand that I may revoke consent for the above at any time, however, I cannot revoke consent for action that has already been taken.

[\_\_\_\_\_\_\_] NON-ENGLISH SPEAKING CLIENT – The contents of this page have been explained to me in my native language

[\_\_\_\_\_\_\_] CLIENTE QUE NO HABLA INGLÉS - El contenido de esta página ha sido explicado en mi idioma natal

[\_\_\_\_\_\_\_] NON-ENGLISH PALE KLIYAN - Yo eksplike mouin sa ki nan paj sa nan Lang natif natal mwen

**THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED.**

**A copy of this form shall be considered equally as valid as the original.**

**MEDICATION QUESTIONAIRRE**

List any **prescription medication**, including birth control, which you (or the client) are currently taking:

Medication Purpose Dose & Frequency Prescribing Doctor

I decline to answer. I understand knowledge of the medications I take may be an important part of my treatment with a therapist and/or psychiatrist.

Initial :

By initialing here, I am attesting that client does not report taking any medications on a regular basis

Initial :

**CORDINATION OF CARE**

Client DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I have authorized Psychamerica/Big Bear Behavioral to use and/or disclose certain

protected health information (PHI) with my/My child’s Primary Care Physician for the coordination of care.

I understand that only the above-specified information can be disclosed by the above-specified organization. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987] - This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature below or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken. A copy or electronic copy of this document shall be as valid as the original. I give permission to fax this form to my primary care provider as listed above.

[\_\_\_] Client reports no PCP.

Big Bear recommends finding a regular PCP

\*\*\* PRIMARY CARE PHYSICIAN \*\*\*

Please complete the following and return to us by fax at 407.540.9552 Thank you

**SELECT ONLY IF YOU DO NOT GIVE PERMISSION TO COORDINATE CARE WITH PCP**

[\_\_\_] I choose not to give authorization for coordination of care at this time.

**TO PRIMARY CARE PHYSICIAN** For *coordination of care.*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**

*(name of doctor or group)*

Phone ( \_\_\_ \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suite # \_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_

(to be completed by Big Bear after diagnosis)

CLIENT IS RECEIVING BEHAVIORAL HEALTH / MENTAL HEALTH SERVICES FOR OUR AGENCY.

CLIENT IS BEING TREATED

FOR THE FOLLOWING DIAGNOSIS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DSM 5 code Name

And is receiving:

\_\_\_\_\_ Individual/Family Counseling

\_\_\_\_\_ Psychiatric Services

\_\_\_\_\_ Mental Health Targeted Case Management

\_\_\_\_\_ Group Counseling

\_\_\_\_\_ Psychosocial Rehabilitation

\_\_\_\_\_ please send medical records regarding the following medical condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is any medical problem or concern that we should be aware of, that would be related or interfere with the above diagnosis, please explain below. You can fax this form back to us.

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Client’s Name: DOB:

**\*\*\* COMPLETE ONE (1) FORM per entity with whom you give permission for Big Bear to share information\*\*\***

I authorize Psychamerica/Big Bear to discuss details of my case and/or to disclose certain protected health information (PHI) to the individual or agency listed below. I understand the information shared is for coordination of care and will be on a need-to-know basis, and that my confidentiality of specific session details is still protected except in situations that require legal notification of other agencies, such as in cases of abuse.

**RELEASE AND RECEIVE INFORMATION WITH:**

*(name of agency/physician/person)*

Fax Phone

Address: Suite #

City State \_\_\_\_\_\_\_\_ Zip Code

**Requested Delivery Method:**

[ ] Fax [ ]Mail [ ]Phone [ ]E-mail [ ]Face to Face [ ] Other

**Purpose**:

[ ] At the request of the client/ guardian [ ] Treatment / Service Coordination

[ ] Disability Application [ ] Other:

**I authorize to release:**

 Psychiatric or Psychosocial Evaluations

 Mental Health Records

 Substance Abuse Records

 Medications & Dosages

 Summary of Progress Notes

 Educational Records

 Physical Health Records/Summary

 Other:

**Other Instructions:** (note: Florida law requires a court order to prevent information release to biological parents or other identified legal guardians):

I understand that only the above-specified information can be disclosed by the above-specified organization. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987] - This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature below or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken. A copy or electronic copy of this document shall be as valid as the original.

**Unless I provide other instructions IN WRITING,**

**This authorization expires 1 (one) year from the date signed, or on \_\_\_/\_\_\_\_/\_\_\_\_\_**

Please submit this request to us in person or:  **Fax – 407-540-9552 or E-mail - Records@BigBearCounseling.org**

*Or Mail:* ***BIG BEAR BEHAVIORAL HEALTH INC, 1009 Maitland Center Commons Blvd, #212, Maitland, FL 32751***