HISPANIC FAMILY COUNSELING, INC.
Orange/Seminole/Osceola/
Main Office: 1707 Orlando Central Parkway, Suite 480 • Orlando, FL. 32809
Phone (407) 382-9079 • Fax (407) 964-1274
referrals@hispafam.com • www.hispafam.com

RECORD #

INTAKE INFORMATION

Client Demographic Information:

Name: _____ **S.S** : ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **DOB:** _____ **Age:** _____

Parents/Caregivers Names: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____

Zip: _____ **Phone:** _____ **Other phone:** _____

Email: _____

Bilingual Required: ☐ No ☐ Yes, Language: _____ **Religion:** _____ **Gender:** ☐ M ☐ F ☐ Other

Legal Status: ☐ Minor in Parent/Guardian Custody ☐ Minor in State Custody ☐ Competent Adult ☐ Incompetent Adult

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: _____ **Disability:** ☐ No ☐ Yes: _____

Race: ☐ White ☐ Black ☐ American/Alaskan Native ☐ Asian ☐ Pacific Islander ☐ Other: _____

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino **Nationality/Countries of Origin:** _____

Emergency Contact Information:

Emergency Contact Name: _____ **Relation to client:** _____

Emergency Contact Number: _____ **Alternative Number:** _____

Other Current Services:

☐ No Other Current Services ☐ Primary Care Physician ☐ Mental/Behavioral Health ☐ Psychiatrist ☐ Probation Officer

☐ Other: _____

Name/Facility/Agency: _____

Funding Information:

☐ Primary Insurance: _____ ID# _____ Copay Amount: _____

☐ Secondary Insurance: _____ ID# _____ Copay Amount: _____

☐ Self-Pay, Amount: _____

School/Work Information:

☐ **School:** _____ **Grade:** _____

☐ Regular Ed. ☐ IEP ☐ Autism Spectrum ☐ ESOL ☐ Other: _____

☐ **Employer:** _____ **Time Working There:** _____

☐ No Current School Enrollment ☐ Not Currently Employed

Referral Information:

☐ Client Self-Referred ☐ Family/Friend Referred ☐ School ☐ Employer (EAP) ☐ Primary Care Physician

☐ Mental Health Provider ☐ Psychiatrist ☐ Case Manager ☐ Probation/Parole Officer ☐ Other: _____

Referring Agency: _____

Household Members:

Name	Relation	Sex	DOB	Comments

OFFICE USE ONLY: Intake Date: _____ Primary Diagnosis: _____ Secondary Diagnosis: _____

Primary Clinician Name: _____

_____ _____

Clinician/Credentials Date

HISPANIC FAMILY COUNSELING, INC.
Orange/Seminole/Osceola
Main Office: 1707 Orlando Central Pkwy, Suite 480 • Orlando, FL 32809
Phone (407) 382-9079 • Fax (407) 964-1274
referrals@hispafam.com • www.hispafam.com

RECORD #

INTAKE CONSENT

Name of Client: _____ Date of Birth: _____

CONSENT FOR TREATMENT AND TREATMENT LOCATION: I am the legal guardian, or I am a competent adult and consent for the above-named client to participate in treatment through Hispanic Family Counseling at the following locations:

YES ◯ NO ◯ HFC Office: (Circle one) Melbourne, Kissimmee, Orlando, Altamonte, Clermont
YES ◯ NO ◯ Client Home: (Address) _____
YES ◯ NO ◯ School: (Address) _____
YES ◯ NO ◯ Other: _____

_____
INITIAL HERE

In the event that you have shared parental responsibility of your child or adolescent, you have a obligation to notify the other parent of services being rendered.

****

- **I give permission and consent for the identified individuals or organizations to take part in the treatment of the above-named client. I acknowledge and understand that the identified persons will have access to confidential information for the intention of assessment and treatment.**

___ Family; ___ Spouse/Partner; ___ Siblings; ___ Grandparents; ___ Parents/Foster Parents; ___ Stepparents; ___ School; ___ Teacher; ___ Principle; ___ Staff; ___ Guidance Counselor; ___ Other; _____
PCP: _____ Telephone: _____
Referral Agency: _____Telephone: _____

CONFIDENTIALITY: Any information about you is considered private and will not be shared with anyone without your consent. There are a few exceptions in which we are required to release information about you.

- We are required to report suspicion of child abuse and neglect to the State of Florida.
- We have a duty to warn potential victims if we believe that their lives are in danger.
- We are required to release a copy of records and/or testimony if subpoenaed in court.
- Parents have the right to be informed about their child's treatment, but the confidences of the child or adolescent will be respected so that an effective therapeutic relationship can be established.

FUNDING AUTHORIZATION: I authorize _____ (insurance name) to pay for services directly to Hispanic Family Counseling, Inc. Is my obligation to be responsible for the charges that this funding source does not cover. I understand that any confidential information will need to be released to the funding agency or resource in order to process any claim and obtain reimbursement.

****

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. A copy of this release shall be valid as the original.

☐ Check here to indicate that you have received a copy of the Client Rights pamphlet, which describes your rights and responsibilities, including whom to contact for complaints and grievances.

- As a courtesy, you might receive phone calls with appointment reminders from your therapist to confirm sessions and coordinate services.

☐ Check here to indicate that you agree to receive text messages, phone calls and emails from HFC, its employees and staff with information regarding appointments, payments, insurance updates and reminders.

Standard text messaging rates and other fees may apply based on your data plan.

(_____-_____-_____) (_____@_____.com)

THIS CONSENT EXPIRES 1YEAR FROM THE DATE SIGNED.

_____ _____
Client/Legal Guardian Signature Date Witness Signature Date

HISPANIC FAMILY COUNSELING, INC.
Orange/Seminole/Osceola
Main Office: 1707 Orlando Central Parkway, Suite 480 • Orlando, FL. 32809
(407) 382-9079 • Fax (407) 964-1274
referrals@hispafam.com • www.hispafam.com

RECORD #

NO SHOW/CANCELLATION POLICY

Client Name: _____ **Birthdate:** _____

Regular attendance at scheduled appointments is very important. Our services will not be effective in helping you if you do not keep your appointments. Irregular attendance, especially a "no show," is also inconvenient and costly for the staff assigned to help you. It is therefore your responsibility to attend all scheduled appointments.

Whenever possible, please notify your assigned clinician at least **24 hours in advance** if you will not be able to keep your scheduled appointment.

CANCELLATION POLICY: If you call your assigned clinician at least an hour before your scheduled appointment, it is considered a "Cancellation," although 24-hour notice is preferred.

1. After the first cancellation, the staff person will call you to reschedule.
2. After two cancellations in a row, the Director will send you a letter explaining that you must call him/her if you desire to continue services.
3. After the third cancellation in a row, services will be terminated.
4. If you cancel three times, with some attendance in between each cancellation, your therapist will discuss with you some possible solutions to the problem of irregular attendance.

NO SHOW POLICY: If you do not call to cancel at least an hour before the scheduled appointment time, it is considered a "No Show."

1. If you fail to notify your assigned clinician prior to a missed in-home session, you will be charged a $25 travel fee to cover the staff cost of traveling to your home for the missed appointment.
2. If you fail to notify your assigned clinician prior to an in-office or in-school session, you may be charged a $25 travel fee if the staff traveled to that location specifically for that session.
3. After the first "No Show," the staff person will call to reschedule the appointment.
4. After the second "No Show," the Director will send you a letter explaining that you must come to the office in person to complete a request to reinstate services if you desire to continue services. In this form, you will be required to renew your commitment to attend sessions or call the staff ahead of time if you need to reschedule.
5. After the third "No Show," your case will be closed.

I understand Hispanic Family Counseling's No Show/Cancellation policy and understand that regular attendance is necessary for treatment to be effective. Therefore, I agree to attend all scheduled sessions. If I cannot keep an appointment, I will call the staff 24 hours in advance to reschedule. If I have an emergency that prevents me from attending, I will call the assigned clinician at least one hour before the appointment to cancel.

_____ _____
Client Signature Date

_____ _____
Parent/Caregiver Signature Date

HISPANIC FAMILY COUNSELING, INC.
Orange/Seminole/Osceola
Main Office: 1707 Orlando Central Parkway, Suite 480 • Orlando, FL. 32809
(407) 382-9079 • Fax (407) 964-1274
referrals@hispafam.com • www.hispafam.com

RECORD #

COPAYMENT AGREEMENT

Client Name: _____ DOB: _____

Insurance Name: _____

☐ I understand that my insurance plan has a deductible of $_____. I understand that I will be required to pay the entire cost of services until this amount is met. The charge for the intake session is $_____ and follow up sessions are $_____ each.

☐ I understand that my insurance plan requires a copayment of $_____ per session. I understand that copayments are due at the time services are rendered.

☐ I understand that I am paying for services on a self-pay plan based on income. The charge for the intake session is $ _____ and follow up sessions are $ _____ each.

I agree to pay the deductible, copayments, and any applicable no-show/cancellation fees in the following manner:

❑ **CASH/CHECK/MONEY ORDER**: I will give the payment to the clinician at the end of each session.

❑ **CREDIT CARD**: I authorize Hispanic Family Counseling to charge the credit card below for the amount listed above for each date of service.

❑ **COMBINATION:** _____

I authorize Hispanic Family Counseling, Inc. to charge the credit card below for the amount and frequency indicated above:

Credit Card type: ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Credit Card #: _____ Exp. Date: _____ Code: _____

Billing Address: _____ Zip Code: _____

Authorizing Signature: _____ Date: _____

INSUFFICIENT FUNDS: I understand that if my check is returned due to insufficient funds, I will be responsible for paying any fees charged to Hispanic Family Counseling, Inc. by the bank. I further understand that I will no longer be able to pay by check and will have to use another payment method (e.g., credit card, cash, money order).

CREDIT CARD DENIAL: I understand that if my credit card is denied, I will no longer be able to pay by credit card and will have to use another payment method (e.g., check, cash, money order)

- I understand that failure to pay a copayment for one session will require that both copayments be paid at the next session. Failure to pay copayments for two consecutive sessions will result in suspension of services until payment is made.
- Hispanic Family Counseling, Inc. is not responsible for any overdraft fees charged by the bank.

This agreement may be amended or terminated at any point. Termination of this agreement does not relieve the obligation to pay for services that have already been rendered.

_____ _____

Client/Guardian Signature Date

Telehealth Consent Form

Patient Name: _____ **Record #**: _____

1. I understand that the service of telemedicine will be provided only under circumstances such as living in remote/rural areas, having special needs, lack of transportation and/or accessibility, or during a national emergency.
2. My consulting therapist has explained to me how the video conferencing technology will be used to affect such a session will not be the same as a direct client/consulting therapist visit since I will not be in the same room as my consulting therapist.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that on such situations, my consulting therapist will suspend connection immediately and schedule another session. I also understand that my consulting therapist or I can discontinue the telehealth session for reasons like: if it is felt that the videoconferencing connections are not adequate for the situation, if the setting does violate privacy, etc.
4. I understand that I must have equipment and a safe place for the services to be provided to not violate privacy.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the session other than my consulting therapist only if help is required to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me; (2) ask them to leave the telehealth room: and or (3) terminate the session at any time.
6. I have had the alternatives to a telehealth session explained to me, and in choosing to participate in a telehealth session. I understand the risks and benefits that it has.
7. In an emergent session (Baker Act required) I understand that the responsibility of the telehealth consulting therapist is to advise police officers as well as my family, friends or relatives and that the consulting's responsibility will conclude upon the termination of the video conference connection.
8. I understand that for billing purposes, an authorization from my insurance company must be conceded before the session.
9. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
10. I have read this document and understand the risk and benefits of the telehealth session and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth session under the conditions described in this document.

By signing this form, I certify: that I have read or had this form read and/or had this form explained to me; that I fully understand its contents including the risks and benefits of the procedure(s); that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Witness Signature Patient's Signature

_____ _____

Witness Name and Credentials Date

_____

Date