Client's Name Admission Date

A Better Therapy Connection Inc. 2014 4th street, Suite 6 Sarasota, Florida 34237
Phone: 941.400.7660 Fax: 941.417.3711
Please email: info@abettertherapyconnection.com Website: abettertherapyconnection.com

GENERAL INFORMATION

Adolescent Intake Form

PERSONAL INFORMATION

Date of Birth Age Social Security Number Medicaid Number

Residence Address City State Zip Code

Telephone (Cell) (Home) (Work) (Email)

Parent/Guardian Relationship Court Ordered? Documentation

Parent/Guardian Address City State Zip Code
(If different from the client)

Parent/Guardian Telephone (Cell) (Home) (Work) Email

REFERRING AGENCY

Agency Address

Person Referring Phone Email

EDUCATIONAL HISTORY: Include school name/location, comments regarding grades and behavior.

Pre-K/Elementary	Middle School	High School	Vocational/College

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EMPLOYMENT HISTORY: Name of current/previous employers, dates of employment and type of work performed.

EXISTING MEDICAL CONDITIONS AND MEDICATION

Describe medical conditions (diabetes, bleeding ulcers, tube feeding, tracheotomy suctioning, apnea monitoring, etc.)

Allergies: (Medications, food, etc.)

Please list all medications:

Medication	Dosage/Frequency	Prescribing Physician/Phone
Medication	Dosage/Frequency	Prescribing Physician/Phone
Medication	Dosage/Frequency	Prescribing Physician/Phone
Medication	Dosage/Frequency	Prescribing Physician/Phone
Medication	Dosage/Frequency	Prescribing Physician/Phone
Medication	Dosage/Frequency	Prescribing Physician/Phone

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Medication	Dosage/Frequency	Prescribing Physician/Phone

PREVIOUS SERVICES (individual/family therapy):

Name of Provider	Dates of Service	Services Received
Name of Provider	Dates of Service	Services Received
Name of Provider	Dates of Service	Services Received

CHECKLIST OF COMMON BEHAVIORAL CONCERNS

PLEASE MARK ALL APPLICABLE ITEMS WITH AN X

BEHAVIOR

NONCOMPLIANCE WITH
- Parental request ( )
- Teacher Instructions ( )
- Medical recommendations ( )
- Requests in public ( )

TANTRUMS ( )
VERBAL ABUSE ( )
AGGRESSION ( )
SEXUAL AGGRESSION ( )
DISRUPTIVE BEHAVIOR
- Interruptions ( )
- Inappropriate behavior ( )
- Out-of-seat without permission ( )
- Other _____
- Other _____

ATTENTION DEFICITS
- W/ excessive motor activity ( )
- WO/ excessive motor activity ( )
- W/ developmental delay ( )
- WO/ development delay ( )

SELF-STIMULATION
- Body rocking ( )
- Hand flapping ( )
- Nail biting ( )

BEHAVIOR continued

RUNNING AWAY ( )
SELF INJURY
- Head hitting ( )
- Arm/hand biting ( )
- Eye gouging ( )
- Other _____

SOMATIC COMPLAINTS
- Headaches ( )
- Abdominal pain ( )
- Other _____

TICS ( )
HAIR PULLING ( )
PHOBIAS ( )

SCHOOL

ACADEMIC UNDERACHIEVEMENT ( )
TRUANCY ()
OTHER _____

ADL/ROUTINES

ENURESIS
- Diurnal ( )
- Nocturnal ( )

ENCOPRESIS ( )
BEDTIME PROBLEMS ( )
FEEDING PROBLEMS

ADL/ROUTINES continued

- Other _____
- Other _____

LACK OF DAILY LIVING SKILLS
- Community survival ( )
- Independent leisure skills ( )
- Independent work/study skills ( )
- Bathing assistance needed ( )
- Supervision needed around bodies of water ( )
- Can swim independently ( )

ACCIDENT PRONENESS
- Burns ( )
- Poisons ( )
- Falls ( )
- Takes unnecessary risks ( )

SOCIAL/COMMUNICATION

INAPPROPRIATE SEXUAL BEHAVIOR ( )
SOCIAL WITHDRAWAL ( )
SOCIAL SKILLS PROVOCATIVE ( )
DEPRESSION ( )
ECHOLALIA ( )
- Immediate ( )

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Thumb sucking	( )	Food refusal	( )	Delayed	( )
Masturbation	( )	Food selectivity by type	( )	NONSENSICAL SPEECH	( )
Other _____		Food selectivity by texture	( )	UNRESPONSIVENESS TO	
Other _____		Hoards food	( )	ENVIRONMENT	( )
PICA	( )	Mealtime tantrums	( )	HYPER/HYPOSENSITIVITY	
PROPERTY DESTRUCTION	( )	Packing food in mouth	( )	TO ENVIRONMENT	( )
STEALIKNG	( )	Absence of thirst	( )	LACK OF APPROPRIATE PLAY	
VEHICLE THEFT	( )	Vomiting	( )	SKILLS	( )
LYING	( )	Vomiting as a result of eating	( )	INSISTENCE ON SAMENESS	( )
FIRE SETTING	( )	Obesity	( )	SOCIAL SKILLS DEFICIT	( )
SUICIDAL VERBALIZATIONS	( )	Underweight	( )	SEPARATION ANXIETY	( )
SUICIDAL ACTIONS	( )	Fear of food	( )	OTHER _____	

SLEEP HABITS

Naptime Bedtime What time does client get up? Sleeping difficulties? Sleep alone or with others? Whom?

Sleeping requirements: Crib Bed Bed with rails Hospital Bed Other (please describe)

PREFERENCES

Please list the client's schedule of regular activities.

What are the client's favorite activities?

What are the client's favorite foods?

Are there certain other foods or activities to avoid? Please list.

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Please list specific fears the client has that staff or service providers should know about (dogs, loud noises).

EMERGENCY CONTACT(S)

Contact Name	Relationship to Client	Phone Number
Contact Name	Relationship to Client	Phone Number

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Client's Name Admission Date

CONSENT FOR TREATMENT

I herby voluntarily request to receive clinical services from A Better Therapy Connection, Inc . I understand that these services may be in the form of:

_____Individual Therapy
_____Family Therapy
_____Group Therapy
_____Mental Health Assessment
_____Random Drug Screen (if deemed necessary)
(*My initials confirm my consent for each treatment)

I also understand that all clinical information will be kept confidential, except as stipulated in Florida Statutes 39, 394, and the Health Insurance Portability and Privacy Act, (HIPPA), as described in the Privacy Notice. The clinical record is the property of and will be retained by the (ABTC). Authorized personnel of the (ABTC) may review my clinical record for the purpose of service provision, clinical supervision, consultation, auditing, and compliance. Portions of my information will be used for billing and payment purposes. This notice will be kept for a period of six (6) years.

I acknowledge of the (ABTC) Client Rights and Responsibilities. I have been given the opportunity to ask questions, and I understand my rights and responsibilities. I have been informed by the (ABTC) staff of the services available through the (ABTC) and agree to participate.

I may revoke my consent, in writing, for any or all services at any time.

Parent/Legal Guardian (if client is a minor or unable to sign) Date

Printed Name / Signature Date

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Client's Name Admission Date

STATEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

All children admitted to A Better Therapy Connection, Inc., are protected by specific rights and have certain responsibilities. These rights and responsibilities provide the framework for the overall individualized treatment plan.

Therapeutic services administered by and through (ABTC), Inc. shall be administered in a manner that protects the child's rights, his or her life, and his or her physical safety.

CLIENTS HAVE THE RIGHT:

- To be treated with courtesy, dignity, and respect without regard to age, race, gender, religion, or disability.
- To understand the availability and range of the services they need and will be utilizing.
- To have visitation and communication with all members of the family, as clinically indicated, in accordance with court orders, and when consistent with the treatment program.
- To have their opinions and recommendations considered in the development and evaluation of the therapeutic services they receive.
- To be safe and free from any form of corporal punishment.
- To request the services of an attorney through their parent and/or legal guardian.
- To have their rights to confidentiality, privacy and appropriate supervision respected within the limits of the law.
- To be the recipient of the highest quality of service, delivered in an efficient and ethical manner.
- To file a grievance and to be given a copy of the agency Client Grievance Procedure upon request.

CLIENTS HAVE THE RESPONSIBILITY:

- To comply with all reasonable rules, policies and requests related to the treatment program.
- To respect the rights to privacy and confidentiality of others.
- To refrain from any activity which may threaten or endanger other clients, staff members or visitors within the (ABTC), Inc., program and to understand that engaging in such behaviors will be cause for reevaluation of appropriateness in the treatment program.

Parent/Legal Guardian Date

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Client's Name Admission Date

Printed Name / Signature Date

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Client's Name Admission Date

INDIVIDUAL RIGHTS FACT SHEET

RIGHTS AFFORDED TO CHILDREN & ADOLESCENTS

Individuals receiving services have the following rights:

1. The right to be treated with respect and dignity: In everyday, routine interactions and at all times.
2. The right to professional, age-appropriate services and treatment.
3. The right to be involved in the services planning process and to express opinions on issues concerning services to be provided.
4. The right to written, informed consent: Company staff is responsible for ensuring informed consent in all relevant instances, such as on matters of importance regarding the kinds of educational, medical, residential or other services and other confidential matters.
5. The right to privacy: Information about individuals receiving services and their activities shall be kept in strict confidence by all persons involved in that care unless the individual or guardian authorizes otherwise. Individuals have the right to have their own place for personal belongings, to be by themselves if capable and so desired, to use the phone without others listening, to open their own mail, to entertain a visitor, etc.
6. The right to be treated as an individual: Individuals receiving services should be able to maximize their own skills and potential. It is the duty of all direct service providers of (ABTC) to assist them to do so.
7. The right to file complaints and grievances, with no retaliation.
8. The right not to be given anti-psychotic medications if they are not desired: Except in an emergency under a physician's order or with court approval.
9. The right to see their own records and to have them explained if necessary: Includes the right to complain or make a formal grievance to program staff if the records are incorrect.
10. The right to refuse to let others see their records: Except under certain conditions.
11. The right not to be discriminated against because of race, color or creed.

I have read and had explained to me the above description of my Individual Rights. I was given a copy.

Parent/Legal Guardian (if client is a minor or unable to sign) Date

Printed Name / Signature Date

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Client's Name Admission Date

ACKNOWLEDGEMENT OF RECEIPT OF INDIVIDUAL RIGHTS FACT SHEET

I hereby acknowledge receipt of the A Better Therapy Connection, Inc., Individual Rights Fact Sheet. I have been given the opportunity to ask questions, and I understand my rights and responsibilities. I have been informed by (ABTC) Staff of the services available through (ABTC) and I agree to participate.

Parent/Legal Guardian (if client is a minor or unable to sign) Date

Printed Name / Signature Date

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GRIEVANCE PROCEDURE
FOR INDIVIDUALS RECEIVING SERVICES

You have the right to let your concerns (grievances) about how you are being treated be known. You have a right to be told the method you can use to let your concerns (grievances) be known. This written notice is a description of how to report grievances and complaints about services you receive from the A better Therapy Connection, Inc. This written notice should be given to you and/or your legal guardian before you begin receiving services with A Better Therapy Connection, Inc.

PROCEDURE:

1. You and/or your legal guardian are not limited in any way in the scope, content or frequency of your grievances.
2. You and/or your guardian may begin the grievance process by telling the person who coordinates your services what your complaint is either in person or in writing. You will be given a form to fill out to describe your concern. Be sure to date it.
3. The person who coordinates your services will review and address the complaint with the guidance of his or her supervisor. If the complaint is about this person, then the supervisor will review the situation.
4. The person who coordinates your services (or the supervisor) will provide you with a written response within ten working days of when you first let the complaint be known.
5. If you disagree with the response, you may take your complaint in writing to the Agency Supervisor. The Agency Supervisor will review the complaint and respond to you in writing within ten working days of when you let the Agency Supervisor know your complaint.
6. If you disagree with what the Agency Supervisor decides, you may take your complaint in writing to the State Director. The State Director will make the final decision and respond to you and your legal guardian in writing within ten working days.
7. Concerns the program staff may have about the possible inappropriate use of this grievance process will be reviewed by your service planning team (which will include a neutral person, such as a referring agency representative or a human rights representative) and will be addressed in your Individualized Treatment plan.

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Client's Name Admission Date

Printed Name / Signature Date

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Client's Name Admission Date

CLIENT CONSENT TO FAX AND EMAIL CONFIDENTIAL INFORMATION

Florida law requires that information contained in medical / mental health records be held in strict confidence and not be released without your written authorization. You will not be denied services based on your refusal to allow your confidential information to be faxed or emailed.

Steps will be taken to make sure your information arrives safely, but faxes and emails can be misdirected.

I do herby authorize (ABTC) located at **A Better Therapy Connection Inc. 2014 4th street, Suite 6 Sarasota, Florida 34237**
Phone: 941.400.7660 Fax: 941.417.3711
, to fax;941.917.3711 or email: info@abettertherapyconnection.com the following information:

_____Psychiatric Information
_____Treatment Plans
_____Assessments
_____Progress Reviews /Quarterly Reviews
_____Diagnosis Information
_____Incident Reports
_____Discharge Summaries
_____Payment Information
_____Other _____

This information may be faxed or emailed to:
The Department of Children and Families
CBCCFL
School District of Residence
Other Mentor staff members
The Agency for Health Care Administration
The Department of Juvenile Justice
Medical Personnel (Specify) _____
Law Enforcement _____
Other _____
Other_____
Other_____

Information that is faxed or emailed will be used for the purpose of treatment planning, placement, reimbursement, other government monitoring.

☐ This option is hereby revoked.

Parent/Legal Guardian (if client is a minor or unable to sign) Date

Printed Name / Signature Date

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Client's Name Admission Date

MEDICAL HISTORY FORM

ENTIRE FORM MUST BE FULLY COMPLETED BEFOR SUBMISSION TO HOCF OFFICES.

Has client been hospitalized or had surgery in the past? ☐ Yes (*please explain) ☐ No ☐Unknown

Details of past hospitalization(s) and/or surgery(ies)

Has client ever had to receive a blood transfusion or blood products? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Relationship	Age	Health: Good or list Illnesses	Mental, Learning or Emotional Illness
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			

Indicate which of the following diseases have been in client's family (including aunts, grandparents, etc.) Y = Yes, N = No, U = Unknown

Condition		Relation to Client	Condition		Relation to Client
Birth Defects			Lung Problems		
Hearing Problems			Gastrointestinal		
Vision Loss / Problems			Kidney / Bladder		
Diabetes			Bleeding Problems		
Anemia			Arthritis		
Cancer			Mental Illness		
Seizure Disorder			Alcohol/Drug/Tobacco		
Migraines			High Blood Pressure		
Developmental Problems			Heart Disease		
Asthma / Bronchitis					

CLIENT'S HISTORY

Indicate which of the following diseases have been in client's family (including aunts, grandparents, etc.) Y = Yes, N = No, U = Unknown

Normal Birth		Bleeding Disorder		Asthma / Bronchitis		Allergies/Hives	
C-Section		Stomach Problems		Short Attention Span		Dry Skin Patches	
Normal Pregnancy		Low Blood Count		Problem Walking		Speech Problems	
Birth Defects		Diabetes		Diarrhea		Tonsillitis	
Hearing Problems		Migraines		Seizure Disorder		Heart Disease	
Anemia		Mental Illness		Kidney / Bladder		Developmental Problems	
Cancer		Lung Problems		High Blood Pressure		Vision Loss / Problems	

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Client's Name Admission Date

Please describe other medical concerns/problems of the client that are not listed above:

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize release of my confidential information as specified below:

A Better Therapy Connection Inc. 2014 4th street, Suite 6 Sarasota, Florida 34237
Phone: 941.400.7660 Fax: 941.417.3711
Please email: Info@abettertherapyconnection.com cc**: abettertherapyconnection@gmail.com**

Name	**Agency**	**Address**	**Phone Number**

To disclose to:

Name	**Agency/Organization**	**Address**	**Phone Number**

The following information:
(check as required)

- ☐ Presence in treatment (verification of admission/discharge dates)
- ☐ Diagnosis
- ☐ Intake and assessment (including psych/medical history)
- ☐ Physical Examination
- ☐ Progress Notes
- ☐ Treatment/Service Plan
- ☐ Discharge Summary
- ☐ Education/school records
- ☐ Other *(specify)*: _____

For the purpose of:

- ☐ Treatment/Service Planning
- ☐ Ongoing treatment
- ☐ Insurance/benefit/funding source approval
- ☐ Other *(specify)*: _____

By this release, I am <u>not</u> giving permission for the receiver of this information to re-disclose this information to any third party. I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at anytime and that in any event this consent expires automatically one year from the date below. I understand that this information may be transmitted via email.

☐ This option is hereby revoked.

Client's Name Admission Date

Parent/Legal Guardian (if client is a minor or unable to sign) Date

Printed Name / Signature Date

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Client's Name Admission Date

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Social Security Number Medicaid Number Date of Birth

This authorizes **A Better Therapy Connection, Inc.** to release and/or receive general medical and psychiatric/psychological information from my client record in accordance with Florida Statutes and Federal Administrative Rules and Regulations. I understand that I have the right to terminate this authorization at any time by signing the designated space below, except to the extent that action has already been taken in accordance with the below authorization. (ABTC) is released from any legal liability that may arise from the release/receipt of the information requested.

Information to be released as follows:

- ☐ Treatment Summary
- ☐ Psychiatric/Psychological Reports
- ☐ History, Physical, Lab Work
- ☐ School Records/Behavioral Reports
- ☐ HIV/AIDS related information
- ☐ Other:

Information to be used for therapeutic treatment of client's presenting issues, treatment planning, treatment reviews, and discharge planning.

☐ This authorization will be valid for 365 days from the date specified below.
☐ This authorization will be valid for communication transmitted via facsimile.

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law (394.459, 396.112, 397.053, 38.609, 455.2416, 390.503, & 42 CFR Part 2). Any further re-disclosure is strictly prohibited. I also understand that checking the box "HIV/AIDS related information" specifically includes treatment summary, history, physical, psychiatric/psychological reports, lab work, test results and/or any other pertinent information.

☐ This option is hereby revoked.

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Client's Name Admission Date

Consent for Primary Care Physician (PCP) Contact

At A Better Therapy Connection, Inc. , we strive to provide the most comprehensive treatment to the individuals we serve. Based on this, we are asking that you allow us to notify the Primary Care Physician of the above-named client to inform of the client's involvement in mental health counseling and/or psychiatric services with (ABTC). This will ensure a continuum of care between practitioners who are committed to the care and well-being of individuals that we provide services to.

At any time that there is a need for communication between practitioners we will send a letter, along with the Release of Information that you sign. The other practitioner will be able to do the same. You may also request this at any point during treatment.

Should you change or add providers we ask that you notify staff working with you so that we can update this information.

Primary Care Physician Specialty Telephone Number

Secondary Physician Specialty Telephone Number

I, or the child to whom I am parent/guardian, currently do not have a PCP and understand that it has been recommended that I obtain one. Should I need assistance with this I will be referred to the Physicians referral program in my area. Once obtained, I will notify the clinician and/or coordinator assigned to my case so that the above process can be completed.

Client or Parent / Guardian Signature Relationship to Client Date

I choose not to have my PCP or any other MD involved with my care be notified of my or my child's involvement in mental health and/or psychiatric services. I understand that should I be prescribed medication or there be a significant event that warrants medical consultation this issue will again be discussed with me.

Client or Parent / Guardian Signature Relationship to Client Date

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Client's Name Admission Date

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I received a copy A Better Therapy Connection, Inc. Privacy Notice. I have had an opportunity to review it and to ask questions. I understand that (ABTC) may sometimes disclose information about me without my consent as required or permitted by law.

I understand that by submitting a written request I may: receive a copy of my file; request an amendment to my file; request alternative communication methods; request limited distribution of information in my file; or obtain an accounting of disclosures. I understand that I will receive assistance as necessary to submit a written request. I understand that I can contact the office or through the Compliance Hotline. I have read and had explained to me the above description of (ABTC) Privacy Notice by my Mental health Counselor/Therapist, who also provided me with a copy of the Privacy Practices.

Parent/Legal Guardian (if client is a minor or unable to sign) Date

Printed Name and Signature Date

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Client's Name Admission Date

HIPAA CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy within fourteen (14) days of the change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you only for the purposes of treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures based upon your prior consent. If you need assistance to make the request in writing, it will be provided to you.

Parent/Legal Guardian (if client is a minor or unable to sign) Date

Printed Name / Signature Date

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Client's Name Admission Date

SUBSTANCE ABUSE ASSESSMENT

❑ Not applicable for this client ❑ Client denies history of substance use

List all substances used and the frequency of use (include any prescribed or over the counter substances abused).

Substance	**Age Started**	**Amount Used**	**How often used?**	**Age Ended**	**Ever attempt to quit?**
Substance	**Age Started**	**Amount Used**	**How often used?**	**Age Ended**	**Ever attempt to quit?**
Substance	**Age Started**	**Amount Used**	**How often used?**	**Age Ended**	**Ever attempt to quit?**
Substance	**Age Started**	**Amount Used**	**How often used?**	**Age Ended**	**Ever attempt to quit?**
Substance	**Age Started**	**Amount Used**	**How often used?**	**Age Ended**	**Ever attempt to quit?**

Please describe attempts to quit drug use on a drug by drug case.

Substance	**Number of attempts to quit and withdrawal symptoms experienced**
Substance	**Number of attempts to quit and withdrawal symptoms experienced**
Substance	**Number of attempts to quit and withdrawal symptoms experienced**
Substance	**Number of attempts to quit and withdrawal symptoms experienced**
Substance	**Number of attempts to quit and withdrawal symptoms experienced**

History of Drug Impact

Has client required more of a substance in order to achieve desired effect? ❑ No ❑ Yes
Has client experienced markedly diminished effect with continued use of the same amount of substance? ❑ No ❑ Yes
Does client recognize substance use as being harmful? ❑ No ❑ Yes
Has client ever attended school impaired? ❑ No ❑ Yes
Has client ever missed school due to substance use/abuse? ❑ No ❑ Yes
Has client ever overdosed on a substance(s)? ❑ No ❑ Yes
Has client ever been hospitalized for substance(s) use? ❑ No ❑ Yes
Has client ever sold substance(s)? ❑ No ❑ Yes
Has client ever committed a crime while impaired? ❑ No ❑ Yes

Describe any Phobias or Paranoia

A Better Therapy Connection Inc. 2014 4th street, Suite 6 Sarasota, Florida 34237
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Religious beliefs that may impact treatment

Regularly attends church/spiritual meetings? ❑ **No** ❑ **Yes**

Printed Name / Signature	**Credentials**	**Date**
Mental Health Counselor	Credentials	Date:
Licensed Mental Health Counselor	Credentials	Date:

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