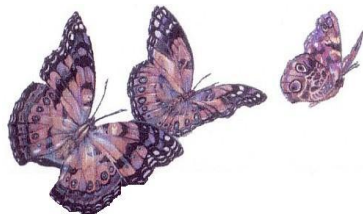


Client Name:



Healing Transitions: Creative Counseling for Children & Families Inc.

Patricia Ann Craven, PhD, LMFT-S, RPT-S
1725 Capital Circle N.E., Alexis Center, Suite 203
Tallahassee, FL 32308
(850) 877-4228 Fax: (850) 877-6968
www.healing-transitions.com

DEMOGRAPHICS INSTRUCTIONS:

All Intake documents must be completed in their entirety prior to services being rendered.

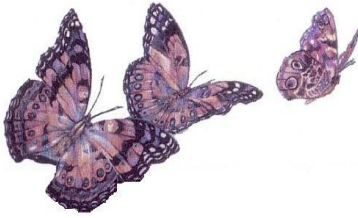
- Attached you will find paperwork for you to complete, printed double sided, that are completed by all new clients and/or their guardians. These instructions are yours to keep.
- On the back of the instructions is your copy of the “Client’s Rights and Responsibilities Statement”
- **Please note:** There are no areas on these forms that require the signature of a minor child. There are some areas that require a witness signature. The clinician that completes the Intake will go over all the information on these forms with you to verify completeness and understanding of the information.

The following areas must be signed by the adult client or legal guardian of a child:

- At the bottom of the front page is the signature of "Consent for Treatment" by the adult client or legal guardian of a minor.
- At the end of the questionnaire: “Confidentiality Statement”
- “Fee Agreement”: Healing Transitions has confirmed your insurance coverage with your behavioral health provider. On this page, the adult client or legal guardian must initial in 3 spaces and sign at the bottom.
 - #1 Initial: “Fee Agreement” Initials are acknowledging that Healing Transitions has confirmed your insurance coverage and will bill your insurance for services rendered.
 - #2 Initial: “Assignment of Benefits” Initial to allow your insurance provider to pay Healing Transitions for services rendered.
 - #3 Initial: “Release of Information” Initial to allow Healing Transitions to send your insurance provider the bill for services rendered.
- “Release of Information”: Please include insurance provider and any other providers involved with this client that we can communicate with.
- “Client Rights and Responsibilities”
- “Photographic/Video Consent and Release”
- “Consent for Primary Care Physician (PCP) Consent and Release”
- “Florida Designation of Healthcare Surrogate”: Only for clients over the age of 18.

If you are unsure of any information, **leave it blank** and the counselor will assist you at the beginning of the Intake session.

Client Name:



Healing Transitions: Creative Counseling for Children & Families Inc.

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CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT

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- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment
- Have their treatment and other member information kept private. Only where permitted by law, may records be released without client permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the client’s benefit plan.
- Share in the development of their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about their insurance provider and their role in the treatment.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input in the Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

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- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the client and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medications changes, including medications given to them by others.
- Keep their appointments. Clients should call their provider as soon as they know they need to cancel visits.
- Let their provider know when the treatment plan isn’t working.
- Report abuse and fraud.
- Openly report concerns about the quality of the care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Client’s Signature

Date

The signature below shows I have explained this statement to the patient. I have offered the member a copy of this form.

Provider:

Date:

Client Name:

HEALING TRANSITIONS
CREATIVE COUNSELING FOR CHILDREN AND FAMILIES INC.
1725 Capital Circle N.E., Alexis Center, Suite 203
TALLAHASSEE, FLORIDA 32308
(850) 877-4228 Fax # (850) 877-6968

FORM MUST BE COMPLETED IN ITS ENTIRETY (IN BLACK OR BLUE INK ONLY)

CLIENT: Name: _____
Last First Middle
SS#: _____ - _____ - _____ Date of Birth: ____/____/____ Gender: _____ Male _____ Female
Race: (Please Circle) 1. White (Non Hispanic) 2. Black (Non Hispanic) 3. Hispanic 4. American Indian or Alaskan Native
5. Asian 6. Native Hawaiian or other Pacific Islander 7. Multi-Racial 8. Other: (please specify) _____
Address: _____ City: _____
State: _____ County: _____ Zip Code: _____
Phone: _____ Home: _____ Cell: _____ Work: _____
Email Address: _____
Name and Address of Current school _____ Highest Grade Completed: _____
School History: _____
Primary Language at home: _____ Religious Preference: _____
Employer: _____ Occupation: _____
Employer Address: _____
Married: Yes _____ No _____ If Yes? Name of Spouse: _____

ADULT CLIENTS: Please skip this box and complete Emergency Contact Information below.

CAREGIVER: (Circle your relationship to the child) Parent Foster Parent (if FP, DCM must sign releases)
Other Relative: _____ Non Relative: _____ Facility: _____
Name: _____
Last First Middle
Phone: _____ Home: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
LEGAL GUARDIAN: Is the caregiver the legal guardian of this child? Yes _____ No _____
If yes, please attach guardianship papers unless you are the biological parent.
If no, please enter the Legal Guardian's relationship, name and contact info? (Circle) DCM Parent Other: _____
Name: _____
Last First Middle
Phone: _____ Home: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
• Is child in foster care? Yes _____ No _____ If yes, is he/her with siblings? Yes _____ No _____

EMERGENCY CONTACT: (Caregivers, please list someone other than yourself for the emergency contact).
Name: _____
Last First Middle
Relationship to client: _____
Phone: _____ Home: _____ Cell: _____ Work: _____

INSURANCE INFORMATION: (Circle) Medicaid None/Self Pay Other: _____
Medicaid ID Number: _____ (Please provide a copy of your insurance card and identification)
Policy or Card Number: _____ Name of Insured: _____

TREATMENT AUTHORIZATION: I hereby authorize Healing Transitions Inc. to provide therapy, counseling, or other services as deemed necessary for the above named client.

Signature of Client or Guarantor Date

Client Name:

PRELIMINARY HISTORY

(The word **YOU** in this history refer to the client. Please use the back of this page if you need more space)

List Present Household Members:

Name	Age	Relation

Who referred you to Healing Transitions Inc.? _____

Are you court-ordered to attend counseling? ____yes ____no If "yes" please explain why:

What problems or treatment goals do you wish to address in counseling?

Have you or your child received counseling or inpatient treatment before? ____yes ____no
If yes, Please explain: _____

- When did problems begin? _____
- Where did problems occur? _____
- Please include time schedule of events _____
- Was the counseling / treatment effective? Yes _____ If "No" Please explain: _____

List Hobbies, Talents, Enjoyable / Volunteer Activities:
• _____
• _____
• _____

List all Peer and Community Supports: i.e. Church, School, Friends, ect...
• _____
• _____
• _____

Client Name:

SOCIAL HISTORY:

Please give a brief timeline of events from birth to present:

BIRTH AND DEVELOPMENTAL HISTORY:

- Place of birth (City, State): _____
- Did you or (the child's mother) have prenatal care? Yes ___ No ___
- How much did (you) or child weigh at birth? _____ lbs. _____ oz.
- Was there any complications at birth? Yes ___ No ___
- At what age did (you) child:
 - Walk? _____
 - Talk? _____
 - Toilet training? _____

**Describe
Childhood:**

Relationships: Describe your relationship interaction with each immediate/extended family member:

- **Mother:**
 - Name: _____ Age: _____
 - Occupation: _____
 - Relationship: _____
- **Father:**
 - Name: _____ Age: _____
 - Occupation: _____
 - Relationship: _____
- **Grandparents:**
 - Names: _____ Ages: _____
 - Occupations: _____
 - Relationships: _____
- **Siblings:**
 - Name: _____ Age: _____
 - Occupation: _____
 - Relationship: _____
 - Name: _____ Age: _____
 - Occupation: _____
 - Relationship: _____
 - Name: _____ Age: _____
 - Occupation: _____
 - Relationship: _____
 - Name: _____ Age: _____
 - Occupation: _____
 - Relationship: _____

Client Name:

FAMILY HISTORY:

Is there a family history of mental health problems? If yes, please explain:

Is there any history of legal problems for the client or family? If "yes" explain briefly: _____yes _____no

Problem Behaviors Checklist: If "yes", please comment on the behavior in the space provided.

School	Yes	No	Comments, times per day/wk/month
Poor Grades			
Difficulty paying attention			
Destructive behavior			
Disruptive behavior			
Doesn't follow rules			
Disrespectful to staff			
Wets self			
Soils self			
Fears going to school			
Skips class/school			
Suspension			

Home

Tantrums			
Bed wetting			
Bed soiling			
Plays with fire			
Stealing			
Lying			
Won't follow instructions			
Physical/verbal aggression			
Damages property			
Running away			
Nightmares			
Eats too much			
Eats too little			
Sleeps too much/too little			

Community

Shoplifting/stealing			
Damage to property			
Poor choice of friends			
Involvement w/ legal system			

Behavior Towards Others

Verbal aggression			
Physical aggression			
Cruel to animals			
Thoughts/threats of killing others			
Argumentative			
Poor peer relations			
Withdraws from others			
Others take advantage of			

Client Name:

Moods/Emotions	Yes	No	Comments, times per day/wk/month
Depressed/ sad			
Crying spells			
Fearfulness			
Worries			
Nervous/ irritable			
Angry			
Mood swings			
Easily upset			
Low energy			
Does not show feelings			

Self- Harmful Behavior

Places self in dangerous situations			
Hurts/cuts self intentionally			
Thinks/Talks of hurting self			
Attempted suicide			

Thinking

Forgetful/looses things			
Has memory loss			
Sees/hears things that aren't there			
Expresses odd beliefs/thoughts			
Suspicious/mistrusts others			
Odd or repetitive behaviors			
Poor judgment			

Physical

Unusual body movements or sounds			
Vomiting			
Headaches			
Stomachaches			
Other physical complaints			
Accident prone			
Health problems/concerns			

Sexual

Masturbates in public			
Touches others inappropriately			
Exposes self to others			
Sexual behavior with objects			
Sexual behavior with animals			
Interest in pornography			
Preoccupation with sex			
Sexual talk/ gestures			
Promiscuity			

Client Name: _____

MEDICAL QUESTIONNAIRE

Allergies: Yes _____ No _____, **List all known Allergies:** to (food, medicine, insects, etc): _____

HEIGHT: _____ **WEIGHT:** _____ lbs. **General Health:** (check) GOOD: _____ FAIR: _____ POOR: _____

Are you or your child currently under the care of a doctor? Yes ___ No ___ (If yes, please state the condition being treated): _____

Physician's Name: _____ **Phone:** _____ **Date of last visit:** _____

Physician's Address: _____

Are you being seen by a psychiatrist? If yes, please name current psychiatrist: _____

Please list medications, if any, that you or your child takes and for what reason:

If Child: Are immunizations current? Yes _____ If "No" please explain: _____

Please list past surgeries or major hospitalizations (include dates): _____

MEDICAL CONDITIONS: Please check any medical conditions of client under CLIENT. Family medical conditions should be listed under FAMILY HISTORY and include the relationship of the relative.

CONDITION	CLIENT	FAMILY HISTORY (Parents, siblings, etc.)
Diabetes		
Stomach Ulcers		
Glaucoma		
Heart Trouble		
High Blood Pressure		
Nervousness		
Liver Disease		
Asthma/Emphysema		
Tumors		
Tuberculosis		
Kidney/Bladder pain		
Bleeding Tendencies		
Rheumatism/Arthritis		
Thyroid Condition		
Anemia		
Seizures		
Gout		
Stroke		
Cancer		
Other:		

Client Name:

PLEASE COMPLETE THIS FORM IF YOU/CHILD IS 11 YEARS AND OLDER.

IF 10 YEARS OR YOUNGER PLEASE CIRCLE: N/A

SUBSTANCE USE ASSESSMENT

Drug	Age of Onset	Longest Period of Sobriety	Date of Last Use	Current Amount and Frequency of Use	Related Problems	
					Alcohol	DRUGS
Caffeine					<input type="checkbox"/>	<input type="checkbox"/> Interpersonal Problems
Tobacco					<input type="checkbox"/>	<input type="checkbox"/> Binges
Alcohol					<input type="checkbox"/>	<input type="checkbox"/> Job Problems
Sedatives					<input type="checkbox"/>	<input type="checkbox"/> Sleep Disturbances
Hallucinogens					<input type="checkbox"/>	<input type="checkbox"/> Physical Withdrawal
Pain Killers					<input type="checkbox"/>	<input type="checkbox"/> Hangovers
Inhalants					<input type="checkbox"/>	<input type="checkbox"/> Arrests
Cannabis					<input type="checkbox"/>	<input type="checkbox"/> Blackouts
Cocaine Method:					<input type="checkbox"/>	<input type="checkbox"/> Medical Complications
Crack Cocaine					<input type="checkbox"/>	<input type="checkbox"/> Assaults
Heroin Method:					<input type="checkbox"/>	<input type="checkbox"/> Passing Out
Ecstasy					<input type="checkbox"/>	<input type="checkbox"/> Seizures
Special K					<input type="checkbox"/>	<input type="checkbox"/> Concern over Use
Prescription Meds					<input type="checkbox"/>	<input type="checkbox"/> Changes in Tolerance
					<input type="checkbox"/>	<input type="checkbox"/> Inability to Stop
					<input type="checkbox"/>	<input type="checkbox"/> Preoccupation w/ obtaining

History of Treatment Attempts	
Alcohol	DRUGS
<input type="checkbox"/>	<input type="checkbox"/> None
<input type="checkbox"/>	<input type="checkbox"/> Stopped on Own
<input type="checkbox"/>	<input type="checkbox"/> Attended OP Program
<input type="checkbox"/>	<input type="checkbox"/> Attended IP Program
<input type="checkbox"/>	<input type="checkbox"/> Attended 12-Step Program
<input type="checkbox"/>	<input type="checkbox"/> Attended Self- Help Group

Self Perception of Use	
Alcohol	DRUGS
<input type="checkbox"/>	<input type="checkbox"/> None
<input type="checkbox"/>	<input type="checkbox"/> Experimental
<input type="checkbox"/>	<input type="checkbox"/> Occasional or Social
<input type="checkbox"/>	<input type="checkbox"/> Problems Use
<input type="checkbox"/>	<input type="checkbox"/> Psychological Dependence
<input type="checkbox"/>	<input type="checkbox"/> Does not Want to Stop
<input type="checkbox"/>	<input type="checkbox"/> Addicted / Cannot Stop
<input type="checkbox"/>	<input type="checkbox"/> Motivated to Stop

HOW MUCH MONEY IS SPENT ON SUBSTANCES WEEKLY?

Client Name:

CONFIDENTIALITY STATEMENT

Healing Transitions may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. Healing Transitions is required by law to maintain your private information confidential, except where disclosure is required or permitted by law. We are bound by a code of ethics to provide you with a notice of our legal duties to keep all your information confidential.

I verify that the above information is correct:

_____ / ____ / _____
Signature **Date**

Client Name:

FEE AGREEMENT

IDENTIFY SERVICE(S):

Standard Rate for Services _____

IDENTIFY CHARGE FOR SERVICE(S):

\$115.00 _____

Actual charges for services will be based upon the Healing Transitions Creative Counseling for Children & Families Inc. sliding fee schedule. Charges will be assessed based upon a review of the individual's or family's circumstances.

CONDITIONS FOR PAYMENT:

1. If you are Medicaid eligible, you understand that you are responsible for providing Healing Transitions Creative Counseling for Children & Families Inc. with your Medicaid number.
2. If you have private insurance, you understand that you may be responsible for a **copayment** and your insurance will be billed and you will be responsible for the remaining charges.

FEE AGREEMENT

Healing Transitions will bill your insurance company for all services provided. If you do not have insurance, you understand that you are responsible for the fees for the treatment services listed above.

_____ INITIAL

ASSIGNMENT OF BENEFITS

I authorize payment of Medicare, Medicaid, and other Third Party Insurer to process my insurance claim for services rendered by Healing Transitions Creative Counseling for children & Families Inc.

_____ INITIAL

RELEASE INFORMATION

I authorize the release of any medical or other information necessary to Medicare, Medicaid, and any other third Party Insurer to process my insurance claim for services rendered by Healing Transitions Creative Counseling for children & Families Inc.

_____ INITIAL

CLIENT NAME (PLEASE PRINT)

ADULT CLIENT SIGNATURE

DATE

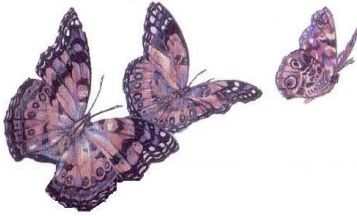
PARENT/GUARDIAN SIGNATURE

DATE

WITNESS SIGNATURE

DATE

Client Name:



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CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT

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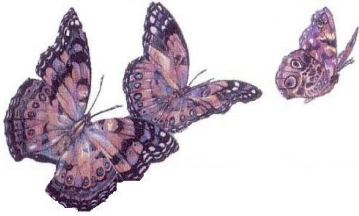
Date

The signature below shows I have explained this statement to the patient. I have offered the member a copy of this form.

Provider: _____

Date: _____

Client Name:



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PHOTOGRAPHIC/VIDEO CONSENT AND RELEASE

I, _____, do hereby consent and agree that Healing Transitions Creative Counseling for Children & Families Inc. employees or agents have the right to take photographs or record video of me and / or my dependents (and/or my property) and to use these in the development of diagnosis, assessment, treatment, and training.

Regarding: Myself Minor Child _____
(Circle One) (Print Name) (Date of Birth)

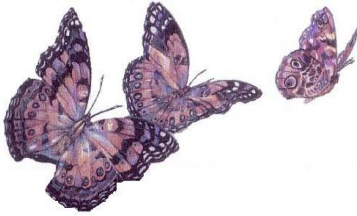
I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Signature: _____ Date: _____

I, _____, **do not** hereby consent and agree that Healing Transitions Creative Counseling for Children & Families Inc. employees or agents have the right to take photographs or record video of me and / or my dependents (and/or my property) and to use these in the development of diagnosis, assessment, treatment, and training.

Signature: _____ Date: _____

Client Name: _____



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RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize
(Print Name of Client or Parent / Guardian if Minor Child)

PCP Name: _____ Telephone: _____

Address: _____

to release and receive confidential information consisting of:

- | | |
|--|--|
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Psychological Records or Information |
| <input type="checkbox"/> Drug/ Alcohol Records | <input type="checkbox"/> Educational or School Records |
| <input type="checkbox"/> HIV or AIDS Information | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical Records or Information | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Other _____ |

Regarding: Myself Minor Child _____
(Circle One) (Print Name) (Date of Birth)

PLEASE LIST ALL PARTIES TO WHOM THE ABOVE INFORMATION MAYBE DISCLOSED

for the purpose of assisting with billing, diagnosis, treatment, rehabilitation and/or delivery of other services to:

Name of Organization: Healing Transitions Creative Counseling for Children & Families Inc

Address of Organization: 1725 Capital Circle N.E., Alexis Center, Suite 203, Tallahassee, FL 32308

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 (42 CFR part 2). 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, June 9, 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 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.

(Signature of Parent/ Guardian, if minor)

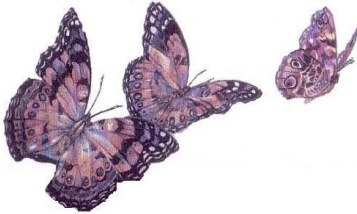
(Date)

(Signature of Witness)

(Date)

If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer:

Client Name:



Healing Transitions: Creative Counseling for Children & Families Inc.

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FLORIDA DESIGNATION OF HEALTH CARE SURROGATE

PLEASE COMPLETE IF 18 YEARS AND OLDER

Name:

(Last)

(First)

(M.I.)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name:

Address:

Zip Code:

Phone:

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name:

Address:

Zip Code:

Phone:

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

In the event I need to go to an area hospital, I choose: _____

These psychiatric advance directives were explained by Healing Transitions staff.

Signature: _____

Date: _____

Witness: _____

Date: _____

Witness: _____

Date: _____

I decline any psychiatric advance directives.

Signature: _____

Date: _____