DEMOGRAPHICAL INFORMATION

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

CLIENT: Name:_____ _____ _____
Last First Middle

SSN:_____ Date of Birth:_____ Gender:_____Male _____Female Other:_____

Race: _____White (Non Hispanic)_____ Black (Non Hispanic)_____Hispanic_____American Indian or Alaskan Native
_____ Asian_____Native Hawaiian or other Pacific Islander_____Multi-Racial_____Other: (please specify) _____

Address:_____City:_____

State:_____County:_____Zip Code:_____

(Phone) Cell:_____ Work:_____ Home:_____

Email Address:_____

Current School:_____ Highest Grade Completed: _____

School History:_____

Primary Language at home:_____Religious Preference: _____

Employer:_____Occupation:_____

Employment History:_____

Married:_____Yes_____No If Yes? Name of Spouse:_____

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

CAREGIVER: N/A or Relationship to Child: Parent Foster Parent (if FP, DCM must sign releases)

Other Relative:_____ Non-Relative:_____Facility:_____

Name:_____ _____ _____
Last First Middle

Date of Birth:_____ SSN:_____

(Phone) Cell:_____ Work:_____Home:_____

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? DCM Parent Other:_____

Name:_____ _____ _____
Last First Middle

(Phone) Cell:_____ Work:_____ Home:_____

Date of Birth: _____ Social Security #: _____

EMERGENCY CONTACT: (Please list someone other than yourself for the emergency contact).

Name:_____ _____ _____
Last First Middle

Relationship to client: _____

Phone: Home:_____ Cell:_____ Work:_____

INSURANCE:_____

Policy / Member ID #:_____

Primary Insured Name:_____ DOB:_____ SSN:_____

(Please provide a copy of your insurance card and Photo identification)

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

_____ _____
Signature of Client or Legal Guardian Date

Client Name:

(The word **YOU** in this history **refer to the client.**

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 any challenges to treatment you may have: ie Transportation, Frequent medical appointments, Inconsistent employment schedule, ect..._____

List Hobbies, Talents, Work / Volunteer Activities:

- _____ _____
- _____ _____
- _____ _____

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

- _____ _____
- _____ _____
- _____ _____

SOCIAL HISTORY:

Please give a brief time-line 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.
- Were 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:_____

MOVING HISTORY:

1._____
2._____
3._____

CURRENT LIVING CIRCUMSTANCES:

_____
_____
_____

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			
hysical/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			

Problem Behaviors Checklist Continued:

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			

MEDICAL QUESTIONNAIRE

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

_____

HEIGHT:_____ inches **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:	☐	
Other:	☐	

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
Caffeine				
Tobacco				
Alcohol				
Sedatives				
Hallucinogens				
Pain Killers				
Inhalants				
Cannabis				
Cocaine Method:				
Crack Cocaine				
Heroin Method:				
Ecstasy				
Special K				
Prescription Meds				

Related Problems

Alcohol	DRUGS	
_	_	Interpersonal Problems
☐	☐	Binges
☐	☐	Job Problems
☐	☐	Sleep Disturbances
☐	☐	Physical Withdrawal
☐	☐	Hangovers
☐	☐	Arrests
☐	☐	Blackouts
☐	☐	Medical Complications
☐	☐	Assaults
☐	☐	Passing Out
☐	☐	Seizures
☐	☐	Concern over Use
☐	☐	Changes in Tolerance
☐	☐	Inability to Stop
☐	☐	Preoccupation w/ obtaining

History of Treatment Attempts

Alcohol	DRUGS	
_	_	None
☐	☐	Stopped on Own
☐	☐	Attended OP Program
☐	☐	Attended IP Program
☐	☐	Attended 12-Step Program
☐	☐	Attended Self- Help Group

Self Perception of Use

Alcohol	DRUGS	
_	_	None
☐	☐	Experimental
☐	☐	Occasional or Social
☐	☐	Problems Use
☐	☐	Psychological Dependence
☐	☐	Does not Want to Stop
☐	☐	Addicted / Cannot Stop
☐	☐	Motivated to Stop

HOW MUCH MONEY IS SPENT ON SUBSTANCES WEEKLY?

_____

_____

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**

FEE AGREEMENT

IDENTIFY SERVICE(S):	IDENTIFY CHARGE FOR SERVICE(S):
Mental Health Assessment	$185.00
Counseling / Session	$155.00
Other:	

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, or your insurance eligibility lapses, you understand that you are responsible for the fees for the treatment services provided.

_____INITIAL

CANCELLATION FEE
I understand that if I fail to cancel a scheduled appointment with less than a 24-hour notice, unless it is due to a documented illness or emergency, I will be billed $25.00 for a "Failure To Cancel Fee". Payment of this fee will be due prior to or at my next scheduled appointment.

_____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)
_____		_____
HT Staff Member:		(DATE)

Healing Transitions Creative Counseling for Children & Families Inc.
Bradenton Address: 3655 Cortez Rd. W. Suite 140, Bradenton FL 34210
Sarasota Address: 3333 Clark Rd, Suite 170, Sarasota FL 34231
Mailing Address: PO Box 1637 Venice FL 34284-1637
(941) 888-2081 Fax: (888) 700-6760
www.healing-transitions.com
www.healing-transitions.com

General Release of Confidential Information

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

Name of Organization: Healing Transitions Creative Counseling for Children & Families Inc.
Address of Organization: PO BOX 1637, Venice, Florida 34284-1637

to release and receive confidential information consisting of:

____	**Psychiatric**	____	**Psychological Records or Information**
____	**Drug/ Alcohol Records**	____	**Educational or School Records**
____	**HIV or AIDS Information**	____	**Other** _____
____	**Medical Records or Information**	____	**Other** _____
____	**Social History**	____	**Other** _____

Regarding: ☐ Myself ☐ Minor Child _____ _____
(Check One) **(Print Name)** **(Date of Birth)**

PLEASE LIST ALL PARTIES TO WHOM THE ABOVE INFORMATION MAY BE DISCLOSED
for the purpose of assisting with billing, diagnosis, treatment, rehabilitation and/or delivery of other services to:

Name of Insurance: _____

Address of Organization: _____

I understand that only the above-specified information can be disclosed by the above-specified organizations. *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 Client) **(Date)**

_____ _____
(Signature of Parent/ Guardian, if minor) **(Date)**

_____ _____
HT Staff Member: **(Date)**

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

_____

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PRIMARY CARE PHYSICIAN 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:

- ____ **Psychiatric**
- ____ **Drug/ Alcohol Records**
- ____ **HIV or AIDS Information**
- ____ **Medical Records or Information**
- ____ **Social History**
- ____ **Psychological Records or Information**
- ____ **Educational or School Records**
- ____ **Other** _____
- ____ **Other** _____
- ____ **Other** _____

Regarding: ☐ Myself ☐ Minor Child _____ _____
(Check 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: PO Box 1637 Venice, FL 34284-1637

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 Client) **(Date)**

_____ _____
(Signature of Parent/ Guardian, if minor) **(Date)**

_____ _____
HT Staff Member: **(Date)**

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

Healing Transitions Creative Counseling For Children & Families Inc.

No show and late cancellation policy

No Show Policy: If a client fails to show for a second missed appointment, it is Healing Transitions' policy to refer the client to another provider. Each missed appointment takes away a time slot that could be used by another client. Our clinicians are very busy and when a client does not show up for their appointment it is time lost for the clinician and another client.

Late Cancellation Policy: It is the policy of Healing Transitions that clients give at least twenty-four hours notice to canceling or changing an appointment. If a client cancels or changes an appointment three times without providing a twenty-four hours' notice, they will be required to talk with the Clinical Director before rescheduling a future appointment.

Received:

_____ Date:_____

Signature Client / Guardian

_____

HT Staff Member:

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"FILE COPY"

Please Read This Important Information

Services:

Healing Transitions offers the following services: Play Therapy, Individual Therapy, Family Therapy, Couples Therapy, Domestic Violence, Anger Management, Substance Abuse, Parenting Education, Therapeutic Visitation, and Psycho-Social Evaluation. All of the above services are offered in the office and/or community based when appropriate and allowed by you insurance. You will be provided your counselor's work cell and all appointment times of service will be scheduled between you and your counselor. All our clinicians are highly trained, qualified, and from diverse mental health backgrounds. Your counselor will either be licensed, or in the process of becoming licensed "Registered Intern" working under the supervision of a licensed professional. We are contracted with many insurances and Medicaid. We also offer a sliding fee schedule for private pay or in cases where we are not able to bill your insurance.

Emergencies: Should you find yourself or a family member in a true emergency situation, you are asked to do the following:

- Contact 911 or proceed to the nearest Emergency room for immediate for life-threatening emergencies.
- Contact our office during business hours (7am-7pm Monday through Friday) to notify us about your emergency and leave a detailed message.
- In the event that you cannot reach us, please call the Clinic Director during business hours, at the office (941) 888-2081 or work cell (850) 838-7866.
- If your emergency is after business hours or on the weekend, you may also call 211 or 800-273-8255 for crisis counseling and referral information. You can also TEXT "741741"
- If you need immediate suicide or crisis counseling, please call 1-800-SUICIDE. (800-784-2433) or visit http://crisistextline.org

Non-Emergency / General Contact Information:

Healing Transitions is committed to providing the highest level of services to every client we are privileged to serve. If at any time you have questions, complaints, or just want to share you appreciation for our services, Please call or email the Quality Assurance Director at 941-888-2081 or contact@healing-transitions.com . You will receive a reply within 24 hours.

APPOINTMENT CANCELLATION POLICY:

Healing Transitions' Professional Staff will schedule your appointment more than 24 hours in advance and will reserve that appointment time specifically for you. If you fail to cancel a scheduled appointment with less than a 24 hour notice, it will not allow us an opportunity to use that time for another client. Therefore; for all cancellations with less than a 24-hour notice, other than due to documented illness or an emergency, you will be billed for a failure to cancel fee of $25.00. A bill will be immediately mailed directly to you and will be payable prior to or at your next scheduled appointment. Thank you for your consideration regarding this important matter.

_____ I have read, understand, and have been provided a copy of this form.
Printed Name of Adult Client / Or Guardian of a Minor

_____ _____
Client Signature (Client's Parent/Guardian if under 18) DATE

_____ _____
HT STAFF Signature DATE

HT Staff signature indicates client read, understood and was provided a copy of this form.

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"FILE COPY"
RIGHTS AND RESPONSIBILITIES STATEMENT

CLIENTS HAVE A RIGHT TO:

- Be treated with dignity and respect.
- 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.

STATEMENT OF CLIENT'S RESPONSIBILITIES

CLIENTS HAVE A RESPONSIBILITY TO:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- 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 client. I have offered the member a copy of this form.

_____ _____

HT Staff Member **Date**

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ADULT FLORIDA DESIGNATION OF HEALTH CARE SURROGATE
(PLEASE COMPLETE IF 18 YEARS AND OLDER)

Name: _____

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: _____

Client Name:_____

Healing Transitions Creative Counseling for Children & Families Inc.

I, _____, hereby (CONSENT FOR TELEHEALTH CONSULTATION)
(Print Name of Client or Parent / Guardian if Minor Child)

1. I understand that my Therapist/Clinician wishes me to engage in telehealth consultations and I have the right to consent or decline consent for future Telehealth services at any time.
2. My Therapist/Clinician has explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room with my Therapist/Clinician.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology including interruptions, unauthorized access, and technical difficulties. I understand that my Therapist/Clinician or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my Therapist/Clinician 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.

CONSENT TO USE THE TELEHEALTH BY ZOOM for Healthcare OR SIMILAR HIPAA COMPLIANT SERVICE

Telehealth by ZOOM for Healthcare or similar HIPAA compliant service is the technology service we will use to conduct telehealth videoconferencing appointments.

By signing this document, I acknowledge:

1. Telehealth by ZOOM or similar HIPAA compliant service is NOT an (Emergency Service) and in the event of an emergency, I will use a phone to call 911.
2. The Telehealth by (ZOOM or similar HIPAA compliant service) ONLY facilitates videoconferencing and is not responsible for the delivery of any healthcare or medical advice.
3. I do not assume that my Telehealth Therapist/Clinician has access to any or all the technical information in the Telehealth by ZOOM or similar HIPAA compliant service – or that such information is current, accurate, or up to date. I will not rely on my Therapist/Clinician to have any of this technical information in the Telehealth by ZOOM or similar HIPAA compliant service.
4. To maintain confidentiality, I will not share my Telehealth appointment link with anyone unauthorized to attend the appointment.
5. I understand that no other person (unknown to my Therapist/Clinician) can be in the same room with me during the telehealth session. All parties involved, listening in on, or attending the telehealth session must be known and approved by me and my Therapist/Clinician prior to and during the entire telehealth session.
6. I understand that neither I the client, ZOOM, or similar HIPAA compliant service, nor my Therapist/Clinician are allowed to video, or audio record a telehealth session without a specific written consent allowing such recording or where allowed by law without consent.

By signing this form, I certify:

- That I have read or had this form read to me, 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.

_____ _____
(Signature of Client) **(Date)**

_____ _____
(Signature of Parent/ Guardian, if minor) **(Date)**

_____ _____
(Signature of Witness) **(Date)**

By signing below, I am acknowledging that I have participated in the formulation of my treatment plan, agree with the treatment goals, agree with the discharge plan criteria, and have been offered a copy of the plan.

Date of Treatment Plan: _____

_____

Client Name

_____

Client Signature Date

_____

Parent/Legal Guardian Name (if applicable)

_____

Parent/Legal Guardian Signature (if applicable) Date

I certify that the above services are necessary and appropriate to the recipient's diagnosis and treatment needs.

_____

HT Staff Member: Date

Healing Transitions Creative Counseling for Children & Families Inc.
Bradenton Address: 3655 Cortez Rd. W. Suite 140, Bradenton FL 34210
Sarasota Address: 3333 Clark Rd, Suite 170, Sarasota FL 34231
Mailing Address: PO Box 1637 Venice FL 34284-1637
(941) 888-2081 Fax: (888) 700-6760
www.healing-transitions.com

"CLIENT'S COPY"

HEALING TRANSITIONS WELCOME LETTER

Healing Transitions is a family owned corporation that desires to meet each individual client at their current level of functioning and assist them to gain the knowledge and tools they need to reach their fullest potential. We are proud to offer a diverse staff of clinical professionals who are trained in "Marriage and Family Therapy", "Clinical Social Work", and "Mental Health Counseling". Every staff member possesses not only the training, skills, and professionalism you would expect from any clinical professional, but also the heartfelt desire to make a difference in the lives of the Children and Families of our community we are privileged to serve.

We offer an open door policy to all our staff and clients. If at any time you have questions, concerns, or want to share you appreciation for our services, please stop by one of our offices at the address listed above. You may also call (941) 888-2081 or 850-877-4228 and request to speak to the Owner, Jeffrey Craven.

⦿ PHILOSOPHY

- Healing Transitions is dedicated to serving children and families who are in need of counseling services involving parenting education, play therapy, family therapy, individual therapy, relationship strengthening, and therapeutic visitation. The services provided are based on the individual need of each client and includes emotional and psychological support. The focus of our service is building relationships with individuals and families. This process of connection includes an emphasis on diversity and acceptance of meeting each individual and family where they are in respect to their chosen path and honoring their current situation with respect and dignity.

⦿ OUR MISSION

- Healing Transitions believes that all individuals have the ability within themselves to reach their full potential. In serving our clients we honor each individuals experience without giving advice or judgment. We don't discriminate by race, religion, sexual orientation, socioeconomic status, and to those who are disabled. We welcome challenging situations and seek out answers by research, psych education, and supervision of those more qualified.

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 required by all new clients and/or their guardians. This welcome letter and instructions are yours to keep.
- On the back of this form is your copy of the "Client's Rights and Responsibilities Statement". Please take time to read this important information.
- **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 Healing Transitions' clinical professional that completes the Intake will go over all the information on these forms with you to verify completeness, your understanding of the information, and sign as your witness.

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CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT

CLIENTS HAVE A RIGHT TO:

- Be treated with dignity and respect.
- 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.

STATEMENT OF CLIENT'S RESPONSIBILITIES

CLIENTS HAVE A RESPONSIBILITY TO:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- 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.

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Please Read This Important Information

Services:

Healing Transitions offers the following services: Play Therapy, Individual Therapy, Family Therapy, Couples Therapy, Domestic Violence, Anger Management, Substance Abuse, Parenting Education, Therapeutic Visitation, and Psycho-Social Evaluation. All of the above services are offered in the office and/or community based when appropriate and allowed by you insurance. You will be provided your counselor's work cell and all appointment times of service will be scheduled between you and your counselor. All our clinicians are highly trained, qualified, and from diverse mental health backgrounds. Your counselor will either be licensed, or in the process of becoming licensed "Registered Intern" working under the supervision of a licensed professional. We are contracted with many insurances and Medicaid. We also offer a sliding fee schedule for private pay or in cases where we are not able to bill your insurance.

Emergencies: Should you find yourself or a family member in a true emergency situation, you are asked to do the following:

- Contact 911 or proceed to the nearest Emergency room for immediate for life-threatening emergencies.
- Contact your counselor's business cell during business hours (9am-6pm Monday through Friday) to notify him or her about your emergency and leave a detailed message.
- In the event that you cannot reach your counselor, please call the Clinic Director during business hours, at the office (941) 888-2081 or (850)-877-4228 or work cell (850) 838-7866.
- If your emergency is after business hours or on the weekend, you may also call 211 or 850-617-6333 for crisis counseling and referral information.
- If you need immediate suicide or crisis counseling, please call 1-800-SUICIDE.

Non-Emergency / General Contact Information:

Healing Transitions is committed to providing the highest level of services to every client we are privileged to serve. If at any time you have questions, complaints, or just want to share you appreciation for our services, Please call or email the Quality Assurance Director at 850-877-4228 or contact@healing-transitions.com . You will receive a reply within 24 hours.

APPOINTMENT CANCELLATION POLICY:

Healing Transitions' Professional Staff will schedule your appointment more than 24 hours in advance and will reserve that appointment time specifically for you. If you fail to cancel a scheduled appointment with less than a 24 hour notice, it will not allow us an opportunity to use that time for another client. Therefore; for all cancellations with less than a 24-hour notice, other than due to documented illness or an emergency, you will be billed for a failure to cancel fee of $25.00. A bill will be immediately mailed directly to you and will be payable prior to or at your next scheduled appointment.

Thank you for your consideration regarding this important matter.