CONFIDENTIAL CHOICES COUNSELING CENTER CONFIDENTIAL

ADOLESCENT INTAKE

Intake Date:_____

Name:_____

SSN:_____-_____-_____ **D.O.B.:**_____ **Gender:** _____**M / F**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Mother's Phone:_____ **Father's Phone:**_____

Parent's Marital Status: ***M***_____ ***S***_____ ***D***_____ ***W***_____ ***SEP***_____

Child lives with: ***Both Parents***_____ ***Father***_____ ***Mother***_____ ***Other***_____

Name of School:_____ **Grade:**_____

Difficulties at/with school? (If yes, please explain):_____

_____

Religious/Spiritual Background:_____

Has your child had previous treatment? (If yes, please explain):_____

_____

What is the presenting problem(s):_____

_____

_____

EMERGENCY CONTACT INFORMATION

Name:_____ **Relationship with client:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: ***cell***_____ ***home***_____ ***work***_____

Please check all your child's behaviors and symptoms that you consider problematic:

- ☐ **Distractibility**
- ☐ **Change in appetite**
- ☐ **Visual hallucinations**
- ☐ **Manipulative behavior**
- ☐ **Hyperactivity**
- ☐ **Withdrawal from people**
- ☐ **Defiance**
- ☐ **No/few friends**
- ☐ **Impulsivity**
- ☐ **Anxiety/worry**
- ☐ **Aggression/fights**
- ☐ **Eating problems**
- ☐ **Boredom**
- ☐ **Panic attacks**
- ☐ **Homicidal thoughts**
- ☐ **Sleep problems**
- ☐ **Poor memory/confusion**
- ☐ **Fear away from home**
- ☐ **Frequent arguments**
- ☐ **Nightmares**
- ☐ **Sadness/depression**
- ☐ **Social discomfort**
- ☐ **Irritability/anger**
- ☐ **Hopelessness**
- ☐ **Phobias**
- ☐ **Peer/sibling conflict**
- ☐ **Fire setting**
- ☐ **Thoughts of death**
- ☐ **Obsessive thoughts**
- ☐ **Stealing**
- ☐ **Work/school problems**
- ☐ **Self-harm behaviors**
- ☐ **Compulsive behavior**
- ☐ **Destroys property**
- ☐ **Legal problems**
- ☐ **Crying spells**
- ☐ **Racing thoughts**
- ☐ **Running away**
- ☐ **Sexual behavior**
- ☐ **Loneliness**
- ☐ **Wide mood swings**
- ☐ **Swearing**
- ☐ **Computer addiction**
- ☐ **Low self-worth**
- ☐ **Suspicion/paranoia**
- ☐ **Curfew violations**
- ☐ **Alcohol/drug use**
- ☐ **Fatigue**
- ☐ **Hearing voices**
- ☐ **Lying**
- ☐ **Lack of motivation**
- ☐ **Recurring, disturbing memories**
- ☐ **Other:_____**

Please check all areas of your child's life that are being affected by their behavior:

- ☐ **Handling everyday tasks**
- ☐ **Self-esteem**
- ☐ **Relationships**
- ☐ **Hygiene**
- ☐ **Health**
- ☐ **Recreational activities**
- ☐ **Work/School**
- ☐ **Housing**
- ☐ **Legal matters**
- ☐ **Finances**
- ☐ **Other:_____**

Please check if your child has experienced any of the following types of trauma or loss:

- ☐ **Emotional abuse**
- ☐ **Neglect**
- ☐ **Fostered/adopted**
- ☐ **Sexual abuse**
- ☐ **Violence in the home**
- ☐ **Multiple family moves**
- ☐ **Physical abuse**
- ☐ **Crime victim**
- ☐ **Homelessness**
- ☐ **Parent substance abuse**
- ☐ **Parent illness**
- ☐ **Parent Separation/Divorce**
- ☐ **Loss of a loved one**
- ☐ **Teen pregnancy**
- ☐ **Financial problems**
- ☐ **Other:_____**

PATIENTS RIGHTS & RESPONSIBLITIES

PROTECTION OF PATIENTS: Unless abridged by a Court of Law, the rights of Patients who are admitted to Choices Counseling Centers' programs must be assured of the following:

PATIENTS:

1. shall be treated by the staff with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy consistent with the need for safety.
2. shall be assigned a primary counselor and the right to know who is responsible for his/her care.
3. shall be given the right to a prompt and reasonable response to questions and requests.
4. shall have the right to know what rules and regulations apply to his or her conduct.
5. have the right to be given information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
6. have the right to refuse any treatment, except as otherwise provided by law.
7. have the right to know that Choices Counseling Center does not accept Medicare assignments.
8. have the right to know a reasonable estimate of charges for medical care (Schedule of fees attached).
9. have the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
10. have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.
11. have the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure as outlined below and to the appropriate state licensing agency.
12. have the right to treatment for any emergency medical condition that will deteriorate from failure to assist client in obtaining treatment.
13. will be afforded access to the least restrictive treatment alternative available consistent with the needs of the client.
14. will be assured that client identifying information is confidential.
15. will be assured freedom from neglect, abuse exploitation, or any form of corporal punishment.
16. will be assured that any search or seizure is carried out in a manner consistent with programs standards and only to insure safety.
17. are responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
18. are responsible for reporting unexpected changes in his/her condition to the health care provider.
19. are responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him/her.
20. are responsible for following the treatment plan recommended by the health care provider.
21. are responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or facility.
22. are responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
23. are responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
24. are responsible for following health care facility rules and regulations affecting patient care and conduct.

_____Initials

CHOICES COUNSELING CENTER
INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

I or We (if a minor) do hereby consent to therapy and authorize the Professional Staff of Choices Counseling Center to render such therapeutic care and treatment as they deem therapeutically appropriate and beneficial to my ultimate goals of therapy.

I or We fully understand that neither Choices Counseling Center nor any member of Its Professional Staff can guarantee the final outcome of my care and treatment. I or We covenant and agree that no warranties of any type or kind have been made to me or us as to the final outcome of my care and treatment. I or We further covenant, agree and certify that no inducement of any type or kind has been made to cause me or us to choose Choices Counseling Center other than information generally disseminated to the general public.

CONDITIONS FOR ADMISSION

1. Any patient may be terminated from care and treatment at any time upon the recommendation of Choices Professional Staff that the patient is failing and refusing to follow the recommendations for care and treatment of Choices Professional Staff. Such termination shall be referred to as a "Termination for Cause," and no part of any advance fees paid are refundable to the patient or their family.

2. By accepting a patient for admission to outpatient treatment at Choices Counseling Center, the Center does not in any way warrant the final outcome of any patient's progress.

3. The undersigned patient and his or her parent or parents acknowledge, covenant and agree that they fully understand that Choices Counseling Center is an outpatient facility only and that all patients who attend Choices Counseling Center programs do so on a strictly voluntary basis and are free to terminate their participation at any time. In the event of a "Voluntary Termination" by the patient, no part of any advance fees paid are refundable to the patient or their family.

4. The undersigned patient further understands that should he or she attend group sessions at Choices Counseling Center, information that may be shared in individual sessions may not necessarily be held apart from group sessions unless specifically requested by patient.

5. Because Choices Counseling Center is an outpatient program, patients who participate in Choices' therapeutic programs may require assistance of Choices Administrative Staff to assist them in finding suitable housing. I or We covenant and agree that we fully understand that Choices Counseling Center does not have any financial interest in any housing where patients of Choices may reside from time to time and that Choices Counseling Center is not liable in any way for the particular living arrangement any patient may make during the course of their therapy.

6. In the event a patient makes a determination to reside with any other patient or patients of Choices in a common facility then and in that event, I or We fully understand that the rules and regulations of that facility must be followed to allow Choices to achieve the maximum possible benefit to the patient. Thus, the failure of the patient to abide by the Rules and Regulations of the living facility shall also constitute good and sufficient grounds for "Termination or Cause" of their Therapy at Choices.

_____Initials

7. I or We have fully read and have had a full opportunity to discuss with the intake member of Choices Professional or Administrative Staff the specific terms and conditions of this Informed Consent and Authorization for Treatment and the Conditions of Admission and I or We agree to abide and be bound by those conditions.

8. Any dispute arising pursuant to this Informed Consent and Authorization for Treatment shall be governed by the laws of the State of Florida and shall be enforceable in the Circuit Court in and for Orange County, Florida and in no other Court or Forum. In the event a patient shall bring an action against Choices arising from their admission, care and treatment at Choices Counseling Center, they shall be fully liable for all of Choices attorneys' fees and costs.

9. I or We personally warrant, covenant and agree to pay all outstanding bills which shall include but not be limited to costs of therapy and medical bills which are due and owing as a result of the care and treatment rendered to me by Choices Counseling Center and its agents and employees within fifteen (15) calendar days from the date the expenses are incurred. This Personal Guarantee is subject to the provisions Florida Law and shall include indemnification of Choices for all actual attorney's fees and costs.

This Consent for Treatment encompasses Schedule of Fees and Office Hours, Agreement for Program Rules, Patients Rights & Responsibilities and Clients Grievance Procedure and are all made a part hereof.

I_____DOB:_____

who reside at_____
covenant and agree that I have read and have explained to me this Informed Consent and Authorization for Treatment and I agree to abide by the terms and conditions of this Agreement.

_____ _____
DATE **PATIENT'S NAME (PRINT)**

_____ _____
PATIENT SIGNATURE **PARENT/GUARDIAN (IF MINOR)**

_____
RESPONSIBLE FINANCIAL PARTY