Start Fresh Counseling Center, Inc

Clinical Services Child Information Form

Please complete this form to the best of your knowledge prior to starting services with Start Fresh. This will help ensure that all contact information is accurate and up to date.

Child Name: _____ Date of Birth: _____

M or F (please circle) Birth Place: _____

Primary Insurance Name/ Number: _____

Secondary Insurance Name/Number: _____

Race: _____ Primary Language: _____

Current Address:

_____

_____

Contact Number of Caregiver:

Home_____ Cell_____

With whom does the child currently reside:

Biological Parents: _____

Foster Parents: _____

Relative: _____

Group Home: _____

Other: _____

Who is the child's <u>LEGAL</u> guardian?

Care Manager Biological Parents Other_____

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Care Manager Name: _____ Agency: _____

Email: _____

Mailing Address: _____

Phone Numbers: Office _____

Cell _____

Fax_____

Biological Parent Info:

Mother

Name: _____

Marital Status: _____

Address: _____

_____

Phone: _____

Father

Name: _____

Marital Status: _____

Address: _____

_____

Phone: _____

Does the child attend School or Daycare? (If answered yes, please provide name and address of the school or Daycare. If answered no, please put N/A)

Yes or No: _____
Name and address of the School or Daycare:

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_____

_____

_____

Who is the child's Primary Care Physician? (Please provide name, address and phone number):

_____

_____

_____

Who is your child's Dentist? (Please provide name, address and phone number):

_____

_____

Does the child have any known allergies? (If yes please explain):

_____

Is the child currently taking any medications? (Please indicate):

_____

_____

_____

Has the child been in psychiatric treatment or counseling? (If answered yes, please list previous provider information and reason):

_____

_____

_____

General Service Release of Information

General Release of Information

I authorize the following person to release information concerning myself/my ward to **Start Fresh Counseling Center**

1._____ 2. _____

3._____ 4. _____

5._____ 6. _____

7._____ 8. _____

9._____

Start Fresh Counseling Center, may release information concerning myself/my ward to the following persons:

1._____ 2. _____

3._____ 4. _____

5._____ 6. _____

7._____ 8. _____

9._____

I understand that this information is valid for 12 months after the date signed, unless I otherwise specify. I further understand that I may revoke the authorization at any time by notifying Start Fresh Counseling Center in writing. By signing this release, the individual/guardian acknowledges the following:

1. Information which may be release including any pertinent medical, educational and psychological information concerning myself/ my ward. Information will be shared with other individual/agencies only when it is needed in providing support for the individual concerning treatment, payment or interest of the Health Information Privacy and Porting Act, do not disclose any individual/ agencies associated with this person, when working with a specific individual/agency, please conceal the other individual/agencies listed above. **Guardian Initials: _____**

Please list the reason for this release of information:

_____

_____

_____

Please list the information and/or document that are being release:

_____

Start Fresh Counseling Center, Inc

_____

_____

2. **Receipt of Privacy Policies:** I have received a copy of the **Start Fresh Counseling Center** Notice of Privacy Practice.

Name: _____ Guardian Initials: _____

3. **Consent for Medical Treatment:** If emergency medical treatment is required, I authorize **Start Fresh Counseling Center** staff to take myself/ my ward for medical consultation. I give my consent for the doctor, the hospital and medical staff to provide treatment that they deem necessary. Routine health maintenance: doctor visits, clinics, dental care and any other partly listed on the release of information are included in this consent. For informed consent on any invasive treatment notify the guardian as soon as possible. **Start Fresh Counseling Center** staff will contact the guardian or identified person(s) immediately to share information or transportation as necessary. **Guardian Initials:** _____

4. **Receipt of the Bill of Rights:** Individuals of their guardians were advised of their rights upon entry or change to any program, upon entry or change in community residence, this document is valid for one year from date of signature. I understand that I may revoke authorization at any time by notifying **Start Fresh Counseling Center** in writing. I have received a copy of the human rights manual. Information was explained to me today. **Guardian Initials:** _____

5. **Notice of Program Procedure:** I give permission to designated personnel at **Start Fresh Counseling** to transport myself/ my ward for regular programming needs. **Guardian Initials:** _____

6. **Photography/Video/Audio Release:** I authorize the use of my/ my ward's image, likeness, and voice for use in **Start Fresh Counseling Center** materials, including the web, social media, and digital/print newsletter; printed, marketing, and public relations material; public service announcements, grants applications, video documentation; and any other purpose in connection to the program deemed appropriate and necessary by **Start Fresh Counseling. Guardian Initials:** _____

7. **Out of State Release:** I give my consent for designated personnel at **Start Fresh Counseling Center** to take myself/ my ward out of state for field trips, doctors' appointments and other operational/programmatic reasons.

Please circle: All Year **OR** Notify Me Each Time Guardian **Initials:** _____

8. **Grievance Procedure: Start Fresh Counseling Center** has a grievance procedure policy in place that is used to resolve conflicts that may arise between the individual receiving services, the guardian and the individual provider. These procedures do not preclude appropriate requests for a hearing, nor do they preempt the individual receiving service, family and guardian's right to request a change in service and/or provider. If you have a complaint

regarding the service, you receive through **Start Fresh Counseling Center** please contact our **Compliance Department at (800) 314-6979.** Upon receiving a grievance compliant, **Start Fresh Counseling Management** director of QI and program Administrator will review complaint and responds to the grievance verbally within 24 hours and in writing within 48 hours. **Start Fresh Counseling Center** will maintain a log for review of all grievance filed with the name of the person making complaint, the date of the complaint, description and the resolution of the compliant.
Guardian Initials: _____

9. **Authorization to Administer Medication:** I give permission to designated personnel at **Start Fresh Counseling Center** to distribute/administer medications and Epi-Pen administration in accordance to state regulations. **Guardian Initials: _____**

Guardian(s) Signature(s): _____

Print Guardian(s) Name: _____

Guardian Phone Number(s): _____

*Please Note: If the individual has co-guardians please make sure that each guardian signs a release form.

Individual's Signature: _____

Print Individual's Name: _____

Date of Birth: _____

Effective on this date: _____

Expires a year from the above date: _____

Informed Consent for Treatment

I authorize **Start Fresh Counseling Center** staff to provide me with the following services: (please check mark)

_____Individual Therapy _____Target Case Mgmt. ____Family Therapy __Group Therapy
____Therapeutic Behavioral Service __Parenting Sessions ____LTC Mobile Assessment
_____Therapeutic Supervised Visitations__Specialized Therapeutic Foster Care
____Psychiatry: Medication Management (only applicable to specialized foster care services)

I consent to the above treatment service and understand that these services are voluntary. If I have any question regarding this consent form or about the service offered at **Start Fresh Counseling Center** I

may discuss them with my therapist. I consent to participate in the evaluation and treatment offered to me by **Start Fresh Counseling Center.** I understand that I may decide to end treatment at any time.

I have read **Start Fresh Counseling Center** informed consent for treatment listed above. This information was explained to me today.

X_____ _____

Individual/Guardian Signature **Date**

I understand that this authorization is valid for 12 months after the date signed, unless I otherwise specify below. I further understand that I may revoke this authorization at any time by notifying Start Fresh in writing.

Print Individual's Name: _____

Print Guardian(s) Name (if applicable): _____

Guardian(s) Signature (if applicable): _____

Phone(s): _____

Consent for Appeals Process

I, _____ (Individual and/or Guardian), give **Start Fresh Counseling Center** permission to appeal any denial for reimbursement of service I have request and/or approved as medically necessary.

_____ _____

Member/Guardian Signature **Date**

_____

Member/Guardian Print Name

Start Fresh Counseling Center, Inc

Start Fresh's Mission

Our mission at Start Fresh Counseling Center is to create a safe, compassionate, and caring environment. Start Fresh Counseling supports improved mental health for families, couples, children and individuals of all backgrounds through Professional Counseling, Psychotherapy services, Life Coaching and Christian Counseling Guided by the teachings of Jesus Christ. We act as a guide in helping the clients to make empowered decisions about their individual and professional lives.

Notification of Privileged Communication

- **FL Statute 491:** Confidentiality and Privileged Communications: Any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential. This secrecy may be waived under the following conditions:

  1. When the person licensed or certified under this chapter is a party defendant to a civil, criminal or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver case the waiver shall be limited to that action.
  2. When the patient or client agrees to the waiver, in writing, or when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.
  3.When, in the clinical judgment of the person licensed or certified under this chapter, there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed or certified under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. There shall be no liability on the part of, and no cause of action of any nature shall arise against, a person licensed or certified under this chapter for the disclosure of otherwise confidential communications under this subsection.

- What does privileged communication meant to me?
  1. Even if it is relevant to a case, a privileged communication cannot be used as evidence in court.
  2. Privileged communications are an exception to the rule "parties generally have access to all information that will help yield a just result in the case".
  3. These relationships are protected for various reasons. If patients were unable to keep secret communications with psychotherapists or physicians relating to treatment or diagnosis, they might give doctors incomplete information. If doctors received incomplete information, they might be unable to administer Health Care to the patient, which is the very purpose of the doctor-patient relationship.

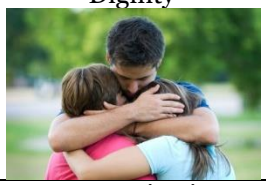
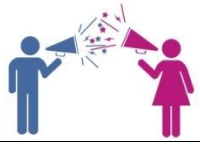
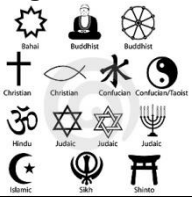
Start Fresh Counseling Center, Inc

- In keeping with our commitment to protect individuals" rights to confidentiality, Start Fresh Will release the following information to individuals listed on the release form for use in court.
    1.Monthly reports
    2.Case Notes
    3.Treatment plans
    4.Initial Assessments
- It is important that you list the individuals that will need access to this information on the release forms attached. If they are not listed, Start Fresh Counseling Center will not be able to release any individuals' information until an updated release is completed. You may way to include the following Individuals on the release:

    1.Care Managers (including courtesy workers)
    2.Biological Parents
    3.Foster parents
    4.Schools
    5.Other Physicians

Start Fresh Counseling Center, Inc

Bill of Rights

Rights	What do these rights mean to you?
Dignity 	My caregivers treat me with respect and kindness and I feel safe and supported.
Communication 	I always have the opportunity to tell people what I want and need and I feel like I am being heard.
Education/ Training 	I always have the opportunity to attend school and participate in educational activities.
Possessions 	I have the right to my own possessions and the right to decide who plays with them.
Religious Freedom 	I have the ability to practice my religion and I feel safe asking questions to decide my religious path.
Medical Treatment 	I have the right to medical treatment and the right to refuse if I feel uncomfortable.
Physical exam before behavior modifications	I have the right to see a doctor before there are any changes to my treatment plan.

	
Humane Discipline 	I have the right to positive discipline and the right to tell someone if I feel hurt in any way.
Behavior and Leisure Activities 	I have the right to play outside and with friends if I choose.
Physical Exercise 	I have the right to exercise or relax if I choose.
Freedom from physical restraints 	I have the right to never physically restrained and the right to tell someone if I feel unsafe.