1301 Seminole Blvd
Building A – Suite 103
Largo, FL 33770

2555 Enterprise Road
Building 9 – Suite 11-1
Clearwater, FL 33763

Family & Adolescent Counseling Services

Phone: (727) 213-5379
Fax: (727) 213-5370
www.SAYHELP.net

Restoring Relationships and Hope in Individuals and Families

Client Information

DATE:_____

Client Name _____DOB _____ Age _____
Address_____
City _____State _____ Zip Code _____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail:_____ Appointment reminder **(check one)** ☐ phone ☐ text ☐ e-mail
Do you want this billed to insurance? _____If so, Insurance Company_____
Policy, Member or Subscriber ID# _____
***IF NOT PRIMARY INSURED - NAME OF PRIMARY INSURED AND DOB*_____**

If Client is a Minor
Parent Name _____DOB_____
Parent Address_____
City _____ Zip Code _____ Referred by_____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail: _____ Contact preference: phone or e-mail?_____
Employer Name _____ Occupation_____

If Client is a Minor
Parent Name _____ DOB_____
Parent Address_____
City _____ Zip Code _____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail _____ Contact preference: phone or e-mail? _____
Employer Name _____ Occupation_____

Other Household Members
Names - Ages - Relationship
_____
_____
_____

Current Medications – Names, Dosages, and Prescribing Doctor
_____
_____
_____

Reason for seeking treatment at this time
_____
_____
_____

PLEASE COMPLETE BOTH SIDES OR CONTINUE NEXT PAGE

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Informed Consent for Treatment and Office Procedures

Family & Adolescent Counseling Services (FACS) would like to welcome you and thank you for entrusting your treatment to us. During the initial visit you will be asked to complete routine forms which will consist of new client information forms, informed consent for treatment, and a release of information (if needed). In general, the number of sessions required for treatment will depend on the issues to be addressed, the recommendations made in the treatment plan, and your commitment to working through the treatment. You are free at any time to terminate treatment if you wish. If you have behavioral health insurance coverage FACS will direct bill to your insurance company. However, please be advised you are fully responsible for any co-pays, co-insurance and any amounts your insurance company does not pay. By signing this consent, you authorize FACS to bill and receive payment from your insurance company on your behalf.

Individual and Family Therapy Sessions are **45-55 minutes** in duration with a fee of $125-175 per session. This includes individual, couples, and family psychotherapy. Telephone sessions (cannot be billed to insurance at this time) can be arranged and will be charged at the regular session rate (prorated based on 15-minute segments). **Please note that all cancellations require a 24-hour notice. If such notice is not given, the session will be billed $75 no show/late cancellation fee.** Checks/Debit Transactions returned by your bank will be assessed a $35.00 non-sufficient funds charge. If any clinician from FACS is subpoenaed for a deposition or to testify in court, the session will be billed at the usual hourly rate, plus travel time billed at the same rate. Evaluations/reports for court cases, social security, and other written reports and treatment summaries etc. will also be charged at the usual hourly rate prorated in 15-minute segments. These are **not** billable to insurance.

Please be assured that all information received from you will be kept **strictly confidential** (as required by law). Absolutely no information will be released about you or your case to anyone without your written authorization and consent. There are exceptions to the law of confidentiality. Such instances include but are not limited to the following:

- I consent to the evaluation and treatment process with Family & Adolescent Counseling Services
- I understand that I have the right to withdraw from treatment at any time
- I have read and understand the Privacy Policy set forth by HIPAA ***(attached to clipboard and available to you)***
- **I understand the Limitations of Confidentiality as noted below:**
  - **Duty to Warn and Protect -** When a client discloses intentions or a plan to harm self or another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client up to and including involuntary hospitalization under Florida Statute 394.467– (Florida Baker Act)
  - **Abuse of Children and Vulnerable Adults -** If a client states or suggests that a child (or vulnerable adult) or has been abused or is in danger of being abused, the mental health professional is required to report this information to the appropriate social service and/or legal authorities including the Florida Child Abuse Hotline.
  - **Minors/Guardianship -** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
  - **Insurance Providers -** (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients to fulfil billing and payment requirements. Information may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I am voluntarily entering treatment, or give my consent for treatment if the client is a minor who is under my legal guardianship. The rights, risks and benefits associated with the treatment have been explained to me.

- Missing or cancelling three appointments without 24-hour notice will result in services being terminated. Initial here ➡ _____
- Treatment billed to insurance requires collaboration with your Primary Care Physician/Psychiatrist if you agree please note who you desire we communicate with _____ Initial here ➡ _____ *If you do not agree skip to next line.*
- I decline to have FACS communicate with my physician. please initial here ➡ _____

_____ _____
Printed Name of Client Date

_____ _____
Signature of client; if under 18, Signature of Parent/Legal Guardian Signature of Witness

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CREDIT CARD AUTHORIZATION

I _____, authorize Family & Adolescent Counseling Services to keep my signature on file and to charge my credit or debit card for the balance of charges related to all transactions not paid by my insurance (if applicable) or my co-payment. If I do not have insurance my counseling fees will be charged to this account as services are rendered.

I authorize Family & Adolescent Counseling Services to charge my credit/debit card for professional services as follows:

- Recurring charges for services for each session.
- I understand and agree that my card will be charged a $75.00 fee for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the Consent to Treatment form I signed.
- I understand this form is valid throughout my treatment unless I cancel the authorization in writing. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy.

Charges will appear on your credit card statement as **FACS Largo, FL**

Verification/Security Code = (MC/Visa/Discover: the 3-digit code on back by signature line. AmEx: above card number, upper-right hand side)

Card Type (circle one): Visa MasterCard Discover American Express

Credit/Debit Card #: _____

Verification/Security Code: _____

Expiration Date: _____

Name as Printed on Card: _____

Billing Address _____

Billing City, State, Zip _____

Billing Phone Number _____

Email Address _____

Client Signature _____ Date _____

FACS Employee Signature _____ Date _____