The Center for Counseling, Growth, and Development
at Jewish Family Services of Greater Orlando

CLIENT INFORMATION

Date_____ Chart #_____

Last Name_____ First Name_____ MI_____

Address_____ Telephone #: _____

City_____ State_____ Zip_____County: _____

E-mail: _____

Does JFS have your permission to e-mail appointment confirmations? Yes/No Initials: _____

Birth date____/____/____ Age_____ Gender __F __M SSN: _____

Emergency Contact Name: _____Telephone #: _____

Assistance Requested: ☐ Emergency Services ☐ Counseling

Have you received services from JFS in the past? ☐ Yes ☐ No If yes, type of assistance: _____

Housing: ☐ Apartment ☐ Hotel/Motel ☐ Mobile Home ☐ Single Family Dwelling ☐ Unknown

Address Type: ☐ Rent ☐ Own ☐ Shelter ☐ Family/Friend ☐ Homeless

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Living Together

☐ Minor: Name of Parent/Legal Guardian(s): _____

The following information is collected for demographic purposes only:

Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Multi-racial ☐ Other: _____

Religion: ☐ Jewish ☐ Other: _____

Spouse/Partner's Name: _____ SSN: _____

List the family members/people who live with you: *(additional lines on the back of this form)*

Name	Age	Relationship

How did you hear about us? *(please check all that apply)*

☐ 211 Community Resources ☐ Physician ☐ School ☐ Family/Friend ☐ Church/Synagogue

☐ Second Harvest ☐ Website ☐ Other Agency: _____

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CLIENT INFORMATION, continued

Date_____ Chart #_____

Last Name_____ First Name_____ MI_____

Please check total monthly income and fill in source(s) of income:

☐ $0- $1,250 ☐ $1,251- $2,083 ☐ $2,084- $4,166 ☐ $4,167- $6,250 ☐ $6,251 and above

☐ Social Security $_____ ☐ Food Stamps $_____ ☐ SSI $_____

☐ Unemployment $_____ ☐ Child Support $_____ ☐ Pension $_____ _☐ Other $_____

☐ Wages $_____ ☐ FT Employment ☐ PT Employment

Insurance Information

Primary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth _____

Client's relationship to Subscriber

__Self __Spouse __Child __Other_____

Secondary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth_____

Client's relationship to Subscriber

__Self __Spouse __Child __Other_____

Do we have your permission to verify your insurance benefits? ☐ Yes ☐ No _____Initials ☐ Verbal consent by phone

I certify that the above information is true and accurate.

Client Signature: _____ **Date:** _____

Data entered ___/____/____ by _____

INFORMED CONSENT TO TREATMENT

Client Name: _____ **Chart #** _____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, with Jewish Family Services of Greater Orlando., hereby referred as JFS. The rights, risks and benefits associated with the treatment have been explained to me. A qualified clinician will provide the agreed upon clinical services. I understand that JFS does employ licensed counselors as well as unlicensed counselors and interns that work under the supervision of a licensed clinician. I understand that if I am not comfortable with the qualifications of my clinician, it is my responsibility to request a re-assignment from the JFS's director or CEO.

I understand that the therapy may be discontinued at any time by either party. JFS encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge. A client may be terminated from therapy non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Center, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner, and/or C) the client does not attend or schedule an appointment for 90 days. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with JFS or request to re-apply for services at a later date.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the JFS Office(s), against any person who works for the Center, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities.

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the JFS duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources. Client records may be reviewed by managed care organizations including your own managed care organization, as well as the Agency for Health Care Administration, and/or its representatives.

I consent to treatment and agree to abide by the above stated policies and agreements with Jewish Family Services of Greater Orlando

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian *if applicable* Date

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Fee Policy & Agreement

Client Name: _____ **Client Chart #:** _____

We welcome you to our Agency and hope you will find our services helpful. Jewish Family Services is a private non-profit organization providing social services to the community. We are supported by client fees.

The cost for Jewish Family Services to provide one hour (1) of counseling services or case management is $120.00. Thus, there is an hourly based fee for any service we provide to you or your family through or home visits. Client fees are an important source of income to JFS and as it is how we pay our counselors.

I agree to the following payment for counseling services:

Per counseling or case management hours, the agency fee is $120.00 per hour. I agree to be responsible for: $_____ based on the sliding fee schedule for clients who meet criteria for a "hardship wavier," (which will be determined by your W-2 forms.)

I understand that my appointment time is reserved **exclusively** for me and/or my dependent. Consequently, if I fail to keep my appointment without providing **24 hours notice, I will be charged,** my agreed upon fee of $_____ for the appointment. I will pay by **cash, check or be charged to my credit card the above amount.**

Credit Card Type:_____ **Credit Card #:**_____ **Exp.Date**_____
CVV_____

If there is any change in my financial condition that might alter the agreement, I will bring it to the attention of my therapist, case manager or coordinator. I agree that charges incurred by me and/or members of my family will be paid in full before my next session. I understand Jewish Family Services reserves the right to alter its fee structure.

For Insurance clients: I authorize the release of any information necessary to process this claim and related claims. I request that payment of authorized benefits be made to Jewish Family Services for any services provided to me by this Agency.

I had the opportunity to ask any questions to help me understand this policy and agreement. I understand and will abide by this policy and agreement.

_____ _____
Client or Responsible Party Signature Date

_____ _____
Client Name (Print) Therapist Signature

Privacy Practices Acknowledgement

My signature below certifies that I have read or have had the opportunity to read the Notice of Privacy Practices that is posted in the Jewish Family Services office. I understand that I may obtain a printed copy of the Notice at any time from any staff member at the Jewish Family Services of Greater Orlando office. I further certify that any questions I have related to the Notice have been answered.

_____ _____
Client or Responsible Party Signature Date

Client Rights Acknowledgement

My signature below certifies that I have read or have had the opportunity to read the Client Rights information that is posted in the Jewish Family Services office. I understand that I may obtain a printed copy of my Rights at any time from any staff member at the Jewish Family Services of Greater Orlando office. I further certify that any questions I have related to the Rights have been answered.

_____ _____
Client or Responsible Party Signature Date