



1759 West Broadway St., Suite 3  
Oviedo, FL 32765  
Phone: 407-977-4335 Fax: 407-977-4370

**SCREENING INFORMATION**

**Please Print Clearly**                      **THIS SHEET MUST BE FILLED IN COMPLETELY**                      Readmit:  Yes     No

Date \_\_\_\_\_ Client's Social Security # \_\_\_\_\_ Client RCC ID # \_\_\_\_\_

Client's First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail: \_\_\_\_\_

Does RCC have your permission to e-mail appointment confirmations?  Yes/ No                      Initials: \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender  F  M    Race \_\_\_\_\_

Name of Spouse/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different than above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

**Emergency Information**

In case of emergency, contact:

Name (1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Current Medication(s) & Dosage(s) \_\_\_\_\_

Allergies \_\_\_\_\_

**Employment Information** (If client is a child, use parent's employment)

Client/Guardian: Place \_\_\_\_\_ Phone \_\_\_\_\_ Hours \_\_\_\_\_

Spouse: Place \_\_\_\_\_ Phone \_\_\_\_\_ Hours \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Contract/ID# \_\_\_\_\_ Group/Acct# \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Client's relationship to Subscriber

Self     Spouse     Child     Other \_\_\_\_\_

**Referral Source**

How did you hear of us (or from whom)? \_\_\_\_\_



1759 West Broadway St., Suite 3  
Oviedo, FL 32765  
Phone: 407-977-4335 Fax: 407-977-4370

**Client Name:** \_\_\_\_\_ **ID#** \_\_\_\_\_

**INFORMED CONSENT TO TREATMENT**

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 Resilience Counseling Center, Inc., hereby referred as the Center. The rights, risks and benefits associated with the treatment have been explained to me. A qualified clinician will provide the agreed upon clinical services, and/or a qualified psychiatrist will provide agreed upon psychiatric evaluations and medication management. I understand that the Center 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 Center's director or CEO.

I understand that the therapy may be discontinued at any time by either party. The Center 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 the Center 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 Center's 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 Center's 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 Resilience Counseling Center, Inc.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 Resilience Counseling Center office. I understand that I may obtain a printed copy of the Notice at any time from any staff member at the Resilience Counseling Center office. I further certify that any questions I have related to the Notice have been answered.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian 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 Resilience Counseling Center office. I understand that I may obtain a printed copy of my Rights at any time from any staff member at the Resilience Counseling Center office. I further certify that any questions I have related to the Rights have been answered.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



1759 West Broadway St., Suite 3  
Oviedo, FL 32765  
407-977-4335

**PAYMENT CONTRACT FOR SERVICES**

Name(s): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Federal Truth in Lending Disclosure Statement for Professional Services:**

**Part One Fees for Professional Services**

I (we) agree to pay Resilience Counseling Center, Inc., hereafter referred to as the Center, a rate of:

\$135 per clinical hour (defined as 45–50 minutes for counseling) for sessions with licensed staff.

\$180 for the first session (defined as 90 minutes to include and assessment as well as a counseling session) with licensed staff.

\$65 per clinical hour for sessions with unlicensed master’s level staff members working under supervision of licensed clinicians.

\$110 for the first session (defined as 90 minutes to include and assessment as well as a counseling session) with unlicensed master’s level staff members working under supervision of licensed clinicians.

A fee of \$ 25 is charged for group counseling sessions.

A fee of \$ 50 is charged for missed appointments or cancellations with less that 24 hours’ notice.

**Part Two Clients with Insurance (Deductible and Co-payment Agreement)**

This Center has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

**Estimated Insurance Benefits with:** \_\_\_\_\_

- 1) \$ \_\_\_\_\_ Deductible amount (paid by insured party)
- 2) Co-payment/co-insurance \$ \_\_\_\_\_ clinical unit.
- 3) The policy limit is \_\_\_\_\_ sessions per  annual  calendar year OR  Unlimited as medically necessary.
- 4) EAP services through \_\_\_\_\_ authorized \_\_\_\_\_ EAP sessions.

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

**Part Three All Clients**

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

**Release of Information Authorization to Third Party**

I (we) authorize Resilience Counseling Center, Inc. to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Resilience Counseling Center, Inc.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Client’s Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



1759 West Broadway St, Suite 3  
Oviedo, FL 32765  
Phone: 407-977-4335 Fax: 407-977-4370

**CONSENT TO RELEASE CONFIDENTIAL INFORMATION to Primary Care Physician**

Client's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, authorize Resilience Counseling Center, Inc. to:

(send)  (receive) the following  (to)  (from) my primary care physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

By the following means:  Verbal  Fax  Electronic (if unchecked, all will be inferred)

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR \*PSYCHOTHERAPY NOTES.

- Admission/Discharge Letter(s) to PCP for coordination of care
- Behavior programs  Treatment/Service plans
- Progress/Summary reports  Bio-Psychosocial Assessment
- Medical reports
- Other, specify \_\_\_\_\_

The above information will be used for the following purposes:

- Planning or Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review  Updating files
- Other (specify) \_\_\_\_\_

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/legal guardian (if applicable)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_