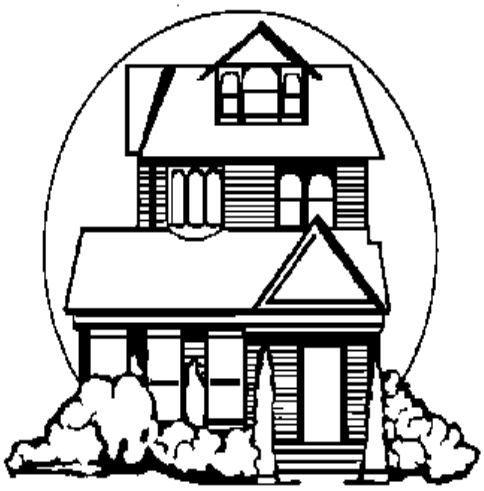
Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

The House Next Door



Therapy Department

Client Intake Packet

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

THE HOUSE NEXT DOOR

Therapy Site: DeLand Today's Date: ____/____/_____

Print name of parent/guardian for minors:_____

Client Name: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

What sex were you assigned at birth, on your original birth certificate? : ☐ Male ☐ Female

Current gender identity. How do you describe yourself? (Choose One)

☐ Male ☐ Female ☐ Transgender ☐ Do not identify as male, female or transgender

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ BiRacial ☐ Other

Ethnicity: ☐ Hispanic or Latino

Ethnicity Detail: ☐ Puerto Rican ☐ Cuban ☐ Mexican ☐ South American ☐ Other Hispanic

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Street Address: _____

Do you wish to be on The House Next Door's mailing list? ☐ Yes ☐ No

Cell phone carrier: Cell Phone #: (_____)_____-_____

OK to contact at home or leave a message? ☐ Yes ☐ No What hours?: _____

Monthly Income from Paid Employment: $_____ Monthly Income from other sources:

Social Security: $ _____ SSI: $ _____ TANF/Public assistance: $ _____ Food Stamps $ _____

# of people in the household: _____ List all individuals in your household:

First Name	Last Name	DOB	Sex	Relationship

Email:_____ Okay to send email? ☐ Yes ☐ No

Please list all medications you currently use:_____

_____

For clients 0-18, please list immunizations:_____

Is religion/ spirituality a source of support for you? ☐ Yes ☐ No

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My cultural identity is: ☐ Very Important ☐ Important ☐ Not Important

Do you have any preferences/ special concerns relating to your religious beliefs/ethnic identity that we need to consider in planning your services? _____

Please check the family structure that best describes your home:

☐ Biological Family ☐ Step-Parent Family ☐ Singe Parent Family ☐ Other (specify):_____
☐ Foster Care ☐ Relative Care Giver

Employer/School:_____ Occupation/Grade Level: _____

Work phone #: (____)_____-_____ OK to contact at work? ☐ Yes ☐ No
When?:_____
Person to be contacted in an emergency: _____ Phone #:_____
Have you, or any member of your immediate family: 1) ever been in a House Next Door program before? ____
2) ever been in counseling? _____
If yes, type of program and where? _____
Who referred you to The House Next Door? _____

I CERTIFY THAT ALL INFORMATION GIVEN ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

☐ By checking this box I consent to this document electronically

_____ _____

Parent Signature- typed signature not accepted Date

_____ _____

Client Signature - typed signature not accepted Date

Fee Information- Office Use Only

☐ WVHA 1505 ☐ AMH 1504 ☐ Teen Court 1500 ☐ Self@_____ 01 ☐ Other:_____
☐ Medicaid ☐ Medicaid HMO:_____ Enrollment #: __ __ __ __ __ __ __ __ __ __
Name of HMO

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

Client Rights & Responsibilities

The House Next Door is committed to providing service to you [the client] without regard to race, sex, color, religion, handicapping condition, national origin, or ability to pay in a manner appropriate to your need.

AS A CLIENT OF OUR AGENCY, YOU HAVE THE RIGHT TO:

INDIVIDUAL DIGNITY, to be treated in a respectful and confidential manner.

NONDISCRIMINATORY SERVICES, to be provided services without regard to race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, or prior service departures against medical advice; to be afforded the opportunity to participate in the formulation and periodic review of your individualized service plan.

QUALITY SERVICES, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

WITHDRAW YOUR CONSENT for any specific activity with no penalty from the agency.

CONFIDENTIALITY OF CLIENT RECORDS, The House Next Door has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality which are listed below:

- If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of the threatened person(s). If abuse or neglect of a child, elder or disabled person is known or suspected, we are required to report it to the Florida Abuse Hotline.
- If our agency receives a court order for client records, staff deposition or court testimony, we are required to comply. We are also required to report attendance compliance by court ordered clients.
- In the course of review of records on agency premises by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payor providing financial assistance or reimbursement to the service provider; however, reports produced as a result of such audit or evaluation may not disclose client names or other identifying information and must be in accord with federal confidentiality regulations.

In the event that group services are provided, it is acknowledged that HND or its staff cannot be held responsible for a breech of confidentiality on the part of a peer group member.

EXPRESS DISSATISFACTION with agency services directly to the Operations Director or to the Executive Director. Forms are available at the front desk at every site to submit a written concern or both the Operations Director and the Executive Director can be reached at 734-7571, Monday – Friday.

AS A CLIENT OF OUR AGENCY, YOUR RESPONSIBILITIES INCLUDE:

Appointments: Regular attendance is very important to ensure progress with the concerns and issues that have been presented. If there is an emergency and you need to cancel or reschedule an appointment, please call the office as soon as you know of this change to reschedule. **Participation**: Your honest and accurate reporting of dilemmas and concerns is vital to your progress. To the best of your ability, you must be open and honest in your sessions and strive to follow the recommendations in your service plan. **Safety**: It is important that you and your children exercise appropriate caution, control and safe behavior on the premises. **Termination**: Services may be discontinued for repeatedly missed appointments; if you come to appointments intoxicated and/or under the influence of substances; or if you show evidence of inappropriate behavior. You [the client] are asked to sign below to verify that you have been made aware of your rights and responsibilities and the policies on confidentiality and have received a copy of both the agency's Notice of Privacy Practices and these rights and responsibilities.

☐ By checking this box I acknowledge that I have received a copy of this form.

_____ _____

Client and Parent Signature -typed signatures not accepted Date

_____ _____

Staff Signature Date

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_____ _____

Client Signature- typed signatures not accepted Date

_____

Date

_____

Parent Signature -typed signatures not accepted

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

THE HOUSE NEXT DOOR THERAPY INFORMED CONSENT

Please read and sign to indicate that you understand the policies and procedures of our Therapy Department.

1. **Services:** We provide many different types of therapy for all ages for families with teens, specialized group therapy, individual, family, and play therapy. Therapy can vary in length depending on the collaborative efforts between therapist and client. The goals for counseling are developed with the therapist, are based on the client's needs and concerns, and are reviewed on a regular basis to monitor progress. Our counseling services are voluntary. If the client has court documentation for counseling, a copy of this documentation must be provided prior to your next counseling session. Social Security numbers of family members receiving services are required for identification purposes and funding requirements. *When bringing children for counseling services or if there are children waiting in the waiting area, the adult providing transportation is required to stay on the premises during the session.*
2. **Appointments:** Regular attendance to therapy is very important to ensure progress with the concerns and issues that have been presented. Please make every effort to keep appointments and be on time. Therapy sessions are typically fifty minutes in length. If there is an emergency and you need to cancel or reschedule an appointment, please call the office as soon as you know of this change to reschedule with your therapist.
3. **Staff:** Therapists providing counseling are Licensed and Registered Clinical Social Workers, Marriage and Family Therapists, Mental Health Counselors, or they are Master Degree Interns in these fields supervised by Licensed Therapists.
4. **Fees:** Therapy session fees are based on the client's income and ability to pay. The fee structure is developed on a sliding scale. All fees are due at the beginning of each session. Some programs are covered by a grant and there is no cost to the clients.
5. **Live Supervision:** The House Next Door is a teaching facility, providing direct supervision to interns and students credentialed and cleared for the provision of therapy services. This involves live supervision/recording in which the session is observed directly by the supervisor or other interns. This process is for training, and clients do this on a voluntary basis. HIPAA guidelines are followed.
6. **Termination:** The client is expected to inform the therapist if the client plans to discontinue counseling for any reason. The final session is an important part of the therapeutic process and helps to summarize the progress and appreciate the change and growth that has occurred. If a client does not show up for two of their appointments without calling to cancel or reschedule, the case file will be closed and a note to the client is sent out. The therapist may discontinue therapy if the client is currently involved in domestic violence with a partner, acute intoxication or impairment, or has shown violent or threatening behavior. The client may be given a referral to other, more appropriate services, for issues of substance abuse requiring more intensive intervention, violence, or sever mental health issues.
7. **Benefits/Risks:** The majority of individuals and families that obtain counseling benefit from the process. Self-exploration, gaining insight, exploring options for dealing with problem behaviors, learning new skills, or venting difficult feelings/experiences are generally quite useful, but some risks do exist. As counseling is begun, please understand that some experience unwanted feelings and that examining old issues may produce unhappiness, anger, guilt, or frustration. These feelings are difficult, but a natural part of the psychotherapeutic process and often provide the basis for change. Important personal decisions are often an outcome of counseling. These decisions, including changing behavior, exploring employment options, substance use patterns, schooling and relationships, are likely to produce new opportunities as well as unique challenges. Sometimes a decision that is positive for one family member will be viewed quite negatively by another. Don't be hesitant to discuss counseling goals, procedure, or your impressions of the services being provided. If ever you don't understand a suggestion or comment that has been made, please ask for clarification.

*****I have read and understand the nature and limits of the therapy services provided by The House Next Door and I agree to participate. I have received House Next Door Privacy Practices-Protective Heath Information.*** _____(initials)**

☐ By checking this box I acknowledge that I have received a copy of this form.

_____ _____

_ Client(s) Signature(s) - typed signatures not accepted **Date**

_____ _____

Therapist's Signature - typed signatures not accepted **Date**

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☐ By checking this box I acknowledge that I have received a copy of this form.

_____ _____

_ Client(s) Signature(s) - typed signatures not accepted **Date**

_____ _____

Therapist Signature **Date**

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The House Next Door Informed Consent for Children in Services
Only applicable for non-offending caregivers

It is important to us that you understand our legal responsibilities in providing service to your child(ren). Florida Statutes mandates that non-custodial parents have equal rights and obligations as custodial parents, unless that authority is restricted by the Courts. If this is applicable in your case, please provide the Court Order that restricts parental privileges.

In the absence of a Court Order, the agency is required to allow both parents to:

- Participate in sessions at the clinical judgment of the therapist
- Have input in developing the goals of the treatment plan
- Have access to the child's records
- Pick up the child from our facility

If both parents do not live in the same house with the child, please be aware that we will attempt to inform the child's other parent that your child is entering services with us.

We appreciate your understanding and cooperation in abiding by these legal requirements.

Name of absent parent: _____
Current mailing address: _____
_____
_____

☐ N/A- both parents live within the same household

I CERTIFY THAT ALL INFORMATION GIVEN ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

☐ By checking this box I acknowledge that I am consenting to this document electronically

Parent signature:typed signature not accepted **Date: _____**

_____

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

AUTHORIZATION TO FILE INSURANCE CLAIMS

I, _____, authorize The House Next Door to file claims to my insurance company which I have listed below for services rendered. I understand that I am financially responsible for any deductible, co-insurance, co-pay or claim denial that my insurance company deems as my responsibility.

☐ By checking this box I acknowledge that I am consenting to this document electronically

_____ _____

Signature of Client- Date

typed signature not accepted

Insurance Company Information: _____

Policy Holder or Subscriber Name:_____

Policy Number:_____

Client's Relationship to Policy Holder:

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other_____

THE HOUSE NEXT DOOR, INC.
AUTHORIZATION TO DISCLOSE AND/OR RELEASE INFORMATION
FOR PRIMARY CARE PHYSICIAN (PCP)

☐ ☐ Deland ☐
114 S. Alabama Ave.
Deland, Florida 32720
(386)-738-9169

I, _____, do hereby
Name of Client/Legal Guardian
authorize the House Next Door, Inc. to disclose information to and/or obtain information

from _____which will include the following:
Name of Primary Care Physician

☐ Admission/Discharge ☐ Progress Notes ☐ Other: _____
☐ Treatment Plan ☐ Summary
☐ Medication Records ☐ Diagnosis _____
☐ Physician Evaluation ☐ Psychiatric Evaluation

Regarding: _____
Client Name **D.O.B.** **Social Security #**

I understand that this information will be used solely to assist in providing appropriate services and will be held in strict confidence. I also understand that in specific circumstances, where required by law and as defined by the agency's Notice of Privacy Practices, my protected information may be subject to re-disclosure.

I understand that I may revoke this Authorization at any time by providing written notice to The House Next Door, as listed above, except to the extent that action has been taken in reliance thereon. I further understand that my refusal to authorize release of records or revoking authorization will not prevent me from receiving services at The House Next Door.

I understand that I have the right to review information disclosed by this release.

If no proper notice of revocation is received, this consent will expire automatically 12 months after the signature dates. A photostatic copy or fax of this document shall be valid and effective as the original.

☐ **Yes.** I consent to the release of information as indicated above to my PCP.
☐ **No.** I do not consent to release information to my PCP.

☐ By checking this box I acknowledge that I am consenting to this document electronically

_____ _____
Client/Parent Signature -typed signatures not accepted **Date**

_____ _____
Therapist Signature **Date**

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

Nurturing Families
Building Communities

The House Next Door

The House Next Door supervises registered interns. All registered interns have completed their course work for graduate school, have earned a master's degree in their field and are closely supervised by a Qualified Clinical Supervisor.

Registered Intern ☐ Name: _____

☐

The supervisor is: ☑ Diahann Suchan,.LMFT 386-738-9169

☐ Ekaterina (Katie) Maza, LMSW ☐

Supervision may include direct or indirect observation. Registered interns may also have to present cases to their supervisor in partial fulfillment of their supervision requirements. I confirm that I understand and agree to the above arrangement.

☐ By checking this box I acknowledge that I am consenting to this document electronically

Signature:
typed signature not accepted

_____Date _____

Witness_____Date_____

_

Client Name:_____

Guardian (if applicable):_____

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.

2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

3. I understand that a telehealth consultation has potential benefits including easier access to care, the convenience of meeting from a location of my choosing and eliminating the risk of exposure to COVID-19 by not coming into the office.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

6. I understand the camera must remain on for the entirety of the telehealth session.

CONSENT TO USE THE TELEHEALTH BY EVOLV

Telehealth by Evol is the technology service we will use to conduct telehealth videoconferencing appointments. By signing this document, I acknowledge:

1. Telehealth by Evolv is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Evolv nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. The Telehealth by Evolv facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By confirming in writing that I have signed this form, I certify:

· That I have read or had this form read and/or had this form explained to me

· That I fully understand its contents including the risks and benefits of the procedure(s).

· That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

SAFETY PROCEDURE:

When a staff member is on a telehealth session with a client in any department and the client is expressing issues that need to be assessed for crisis, the following is the procedure:

1. The staff member will assess the safety of the client and those in proximity to the client.
2. The staff member will determine if there is a need for outside resources such as the sheriff or a clinician to assess.
3. If a need is determined, while keeping the client on the line, the staff member will contact the supervisor for the department to discuss the need. This may be done via text or phone call depending on the situation. The staff member will brief the supervisor of the situation.

a. If the supervisor determines a need, they will contact the clinical director to assess the situation and potentially the client.

b. If the supervisor determines an immediate situation, the supervisor will contact the Volusia County Sheriff Department Non-Emergency line 386-248-1777 to request a Baker Act assessment of the client. The supervisor will need the following information to give.

i. Name of the client
ii. Address of the client current location
iii. Phone number of the client if known
iv. Others in the home that may be in danger or as a resource
v. Staff name who is on the session/telehealth with the client
vi. Staff phone number

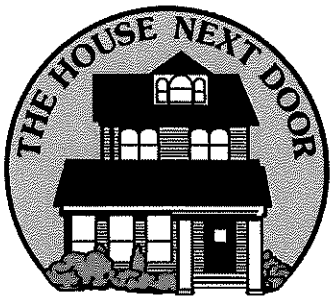
☐ **BY CLICKING ON THE CHECKBOX I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.**

_____ _____

Client Signature : **Date**

_____ _____

Parent or Guardian Signature (if applicable) **Date**



Nurturing Families
Building Communities

Non Discrimination and Special Needs Policy

The House Next Door is a family counseling, parenting and prevention organization providing services to families in Volusia, Flagler and Putnam Counties. This service is provided without regard to race, sex, sexual orientation, color, religion, handicapping condition, or national origin.

Non-English speaking clients have the right to a translator, at no charge. Deaf and Hard of Hearing clients have the right to services delivered in their preference style, i.e. written, oral interpreter, finger spelling, manual interpreter, at no charge to the family.

The agency does require the client to give a 72 hour advance notice to allow for accommodations to be made.

If you believe your rights have been violated, you can contact:

Florida Abuse Hotline
1-800-96-ABUSE
1-800-962-2873 (Voice)
1-800-453-5154 (TTY /TTD)

Americans with Disabilities Act (ADA)
1-800-514-0301 (Voice)
1-800-514-0383 (TTY)

Disability Rights
Florida
1-800-342-0823 (Voice)
1-800-346-4127 (TTY/TTD)

Office of Substance Abuse & Mental Health 1-904-485-9583

Important Resource Numbers

Florida Abuse Hotline	1-800-96-ABUSE 1-800-453-5154 (TTY/TTD)
Disability Rights Florida	1-800-342-0823 1-800-346-4127 (TTY/TTD)
Local Domestic Abuse	386-255-2102
Suicide & Crisis Lifeline	988
United Way Resources	211

Office of Substance Abuse and Mental Health

904-485-9583