Patient Chart # ____________________

REFERRAL FORM

Name: ____Age: _______ DOB: ________________ Gender: ☐Male ☐Female
Address: ____
City: ____ State: ___________ Zip: ________________________
Primary Phone: (_______) __________________________ Email: ____
Secondary Phone: (_______) __________________________ Leave Messages: ☐ Yes ☐ No
If Minor, where does the child currently reside? ☐ Both Parents ☐ Mom ☐ Dad ☐ Joint Custody (Specify below)
Other: ____________________________________ Joint Custody Arrangement: ___________________________________

Parent/Guardian's Name: _____________________________________ Relationship: _______________________________
Current Address: ____ Phone: ________________________________

Parent/Guardian's Name: _____________________________________ Relationship: _______________________________
Current Address: ____ Phone: ________________________________
Type of Insurance: ☐ Medicaid Policy / Member ID: ____
☐ ChildNet SSN: ____
☐ Self Pay

****

Referring Agency: ____ Date: ______________________________
Referral Name: ____ Title: _______________________________
Phone: ____ Fax: ____

Reason for Referral (check all that applies):

	Symptom		Symptom		Symptom		Symptom		Symptom		Symptom
	Death		Drug Abuse		Anger		Self-Esteem		Domestic Violence		Child Abuse
	Divorce		Custody		Depression		Child Abuse		Family Conflicts		Medication
	Sleep Problems		Suicidal Thoughts		Poor Health		Run Away		Social Skills		Mental Illness
	Child Neglect		Crime Victim		Financial		Anxiety		Truancy		Homeless
	Sexual Abuse		Parenting		Legal Issues		Other				

Service(s) Requesting: ☐ Individual Therapy ☐ Family Therapy ☐ Substance Abuse Counseling
☐ Anger Management ☐ Parenting ☐ Substance Abuse Evaluation
☐ Psychiatric Evaluation ☐ Biopsychosocial
Court Ordered? ☐ Yes ☐ No Court Date: ___________________ If Evaluation, need by _________________

Previous behavioral / mental health treatment: ☐ Yes ☐ No Where: ____________________ For what: _________________
Successfully Completed: ☐ Yes ☐ No Is this referral pending acceptance elsewhere? ☐ Yes ☐ No

Preferences for treatment: Primary Language: _____________________ Therapist: ☐ Male ☐ Female
☐ Office ☐ Home ☐ School ☐ Morning ☐ Afternoon/Evening
☐ Weekdays ☐ Weekends

Therapist Assigned: ________________________________ Staff Signature: ____

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Patient Chart # ____________________

ADULT INTAKE FORM

Name: ________________________________Age: _______ DOB: ________________ Gender: Male Female
Address:____
City: ____ State: ___________ Zip________________________
Phone: Home(_______) __________________________ Email: ____
Citizen: Yes No Primary Language: ___________________________ Religion: ____________________________
Race: Black White American Indian Alaskan Native Hispanic
Ethnicity: African American Puerto Rican Cuban Mexican Caucasian Other Hispanic Haitian Other:
____

Living Arrangements: Living at home with Biological Parent(s) Living with extended family Living with foster parent(s)/protective services Living Alone Homeless

Parent/Legal Guardian Information

Parent/Legal Guardian: ___________________________________ Relationship: _______________________________
Address: ____
City: ____ State: ___________ Zip: ______________________
Phone: Home (______) ____________________ Cell (______) ________________________
Email: _______________________________________

Emergency contact: _________________________________ Relationship: ____________________________________
Address: ____
City: ____ State: ___________ Zip:_______________________
Phone: Home (______) ___________________________ Cell (______)_____________________________________

List all family members or significant others involved and their relationship to the patient.
Name: ____________________________________ Age: _________ Relationship: ___________________
Name: ____________________________________ Age: _________ Relationship: ___________________
Name: ____________________________________ Age: _________ Relationship: ___________________
Name: ____________________________________ Age: _________ Relationship: ___________________
Name: ____________________________________ Age: _________ Relationship: ___________________

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Patient Chart # ___________________

Primary Care Physician: _________________________________ Phone: __________________________________

Pharmacy Name: _____________________________________ Phone: _________________________________

Allergies: Food: ____________________ Medication:__________________ Other:_______________

SSN: ____ Medicaid ID: ___________________________________

Private Insurance Name:____

ID: ______________________________________ Group #:____

Address: ____

Phone: _____________________________________ Fax: ____

Are there any other agencies involved with the patient (DCFS, Child Welfare, Courts, etc.)?

____

____

****

History of Problem

Please describe what concerns you have:

____

____

____

How long has the problem existed? ____

____

Have there been any significant stressors: losses, births, deaths, moves, hospitalizations, financial problems, within the last five years?

____

____

____

Patient Chart # ___________________

What attempts have been made to resolve the difficulties? ____
____

Explain how you would like for Intecelle to help:
____
____

Please check the symptoms that the child is currently experiencing.

	Symptom		**Symptom**		**Symptom**
	Physical Sickness		Nightmares		Fighting
	Death in Family		Unable to Relax		Angry
	Changes in Appetite		Weight Change		Feelings of Hostility
	Sadness/Depression		Acts of Violence		Social Isolation
	No Energy		Strange Thoughts		Job Loss/Broke
	Frustration		Head Aches		Drug Use
	Suicidal Thoughts		Phobias		Sleep Problems
	Inability to Concentrate		Obsessive Thoughts		Tension and Anxiety
	Panic Attacks		Memory Problems		Compulsive Behaviors
	Hyperactivity		Marital Problems		Alcohol Use
	Homeless		Domestic Violence		Others

List any other problems or feelings not identified above:
____
____
____

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Patient Chart # ____________________

Statement of Rights

This agency is committed to ensure that you receive professional humanistic services, directed towards your needs, in a manner that protects your dignity and feelings of self-worth. To this end, the following Statement of Rights have been formulated:

CIVIL RIGHTS

1. You have the right to be treated with dignity and respect.
2. You retain all rights, benefits, and privileges guaranteed by law.

DISCRIMINATION

1. Services will be provided to you and/or your family members without discrimination. Ethnic background, personal or social creed, racial membership, sex, religion, or age will not affect our services to you.
2. You will not be refused any services based on lack of or limited personal financial resources. Travel and loss of work time will be discussed and kept at a minimum. No physical barriers will preclude treatment.
3. Services will be provided with a minimum waiting time. Agency service hours will be reasonably convenient to all requesting services.

CONFIDENTIALITY

1. Your medical and social service records are confidential and cannot be released to anyone without express consent given by you or your legal guardian. However, the Court without your permission can subpoena your records, especially if you are court-mandated to treatment. Also, knowledge of child abuse, elder abuse, and intent to harm yourself or others must by law be reported in addition to knowledge of communicable diseases (e.g., hepatitis).
2. You have the right to review and approve any information being requested by another agency that is providing services to you.

TREATMENT

1. You have the right to an individual plan for treatment and will be expected to participate in your plan for treatment.
2. You have the right to know the name and professional credentials of anyone working with you.
3. You may request to participate in any staff meeting regarding yourself or your child.
4. You may review your clinical record upon written request.
5. You will be advised of the positive effect and possible complications of any drug or medication prescribed by any physician involved in your treatment.
6. You have the right to refuse to participate in or be interviewed for research purposes.
7. You have the right to refuse any electronic and/or visual recording of your treatment without your expressed written approval.
8. You have the right to terminate treatment at any time.

GRIEVANCE PROCEDURE

1. If you feel that your treatment program has not been provided fairly or reasonably, you may present your concerns in writing to Intecelle's management/supervisory staff.
2. You have the right to legal recourse. You have the right to confer with family, attorney, physician, clergyman, and others at any time.
3. You may contact the Alcohol, Drug Abuse, and Mental Health Office of the Department of Children and Families at (954)467-4298 of you have a grievance regarding the treating agency.
4. You are under the protection provided under Florida Statute 491 Section 10E-16004(27) as follows "Protection of Patient's- the rights of the patients who are admitted to this program shall be assured and defined in each program operating standards. This shall include operating standards, which protect the dignity, health, and safety of patients".

EVALUATION

Consistent with providing professional and quality services, you will be given an opportunity to evaluate all aspects of your services and the personnel with whom you were involved. (You may be asked to evaluate your treatment, in writing, during or upon completion of treatment).

I HAVE READ AND UNDERSTAND THE STATEMENT OF RIGHTS FOR INTECELLE, INC.

Patient Name (print): ________________________________ Signature: _________________________ Date: ________________

Parent/Guardian Name (print): _________________________________ Signature: _____________________________________

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Patient Chart # ____________________

Consent for Treatment & Participation

I _____________________________________(***Patient Name***), request to be admitted to Intecelle, Inc. (Intecelle) for any of the following services; assessment, evaluation, observation, social services, case management, parenting training, counseling, and other treatment services.

Medication Policy:
If medication needs are identified, I agree to comply with medication treatment as prescribed by the medical doctor or nurse affiliated with Intecelle. It is our policy **Not** to renew medications over the telephone. Prescription refills are disbursed only at the time of an office visit. All PATIENTS on medication must be monitored closely. Therefore, it is imperative that patients keep their appointment with their medical doctor.

Litigation Disclosure:
I understand that Intecelle's staff and/or consultants will not become involved with custody battles or other legal exchanges with attorneys, etc. Intecelle will exchange written information to the Patient or the Patient's legal guardian, and it will be up to the Patient or Patient's legal guardian to share the information with attorneys or other interested parties.

Fee Agreement:
I understand that while I am participating in treatment, I may be expected to pay a fee for all social and/or medical services that I received, unless other fee arrangements are made. I understand that Intecelle will bill any of the following sources:

☐ Government Funded Programs (free of charge), including **Medicaid** or **Medicare**

☐ Private Insurance and I will pay the co-payment of $_______ per session

☐ Self-pay and I will pay the full cost of $________ per one (1) hour counseling session.

I also understand that I may be charged the regular fee for appointments that I miss unless cancelled within 24 hours of my scheduled appointment time.

Treatment Start Date:___________ Initials:__________

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTOOD, AND CONSENT TO THE ABOVE.

Patient Name (print): ________________________ Signature: _________________________Date: _______________________

Parent/Guardian Name (print): __________________________ Signature: _______________________ Date: ________________

Witness Name (print): ________________________ Signature: _________________________ Date: _______________________

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<u>Notice of Privacy Practices</u>
<u>HIPAA: Acknowledgement of Receipt</u>

The undersigned understands that Intecelle, Inc. is required by law to maintain privacy of protected health information and has provided the patient /patient's representative with a notice of its privacy practices regarding health information. I understand that if Intecelle uses my personal health care information in a manner that is different than described by the Notice, Intecelle, Inc. must first get my permission.

I am accepting this Notice on behalf of:

☐ Myself

☐ Patient Representative (Parent, Guardian, Family member, etc.)

I understand that my signature on this Acknowledgment does not authorize Intecelle to disclose my personal health care information without a separate signed consent or authorization.

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES OF INTECELLE, INC.

Patient Name (print): ________________________ Signature: _________________________Date: _______________________

Parent/Guardian Name (print): __________________________ Signature: _______________________ Date: ________________

Witness Name (print): ________________________ Signature: _________________________ Date: _______________________

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Consent for Coordinating Care

By checking the following:

_____ I **AGREE** to have Intecelle, Inc. correspond and/or obtain information pertinent to care from my primary medical physician. This includes recent medical evaluations, laboratory reports, medications, etc.

Physician Name: ____

Address: ____

Phone: ____

Fax: ____

____ I **DECLINE** to have Intecelle, Inc. correspond and/or obtain information pertinent to care from my primary medical physician.

I understand that general medical information is needed to coordinate my general mental health care activity. This authorization will terminate one year from the date of my signing and is subject to revocation/amendment at any time during my treatment.

Patient Name (print): _______________________ Signature: ________________________Date: ______________________

Parent/Guardian Name (print): _________________________ Signature: ______________________ Date: _______________

Witness Name (print): _______________________ Signature: ________________________ Date: ______________________

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Patient Chart # ____________________

CONSENT FOR FOLLOW-UP CARE

I ____________________________________ (***Patient Name***), give permission to contact me for purposes of obtaining follow-up information concerning my post treatment behavior.

Address: ____
City: ____ State: ___________ Zip: ______________________
Phone: Home (______) _____________________________ Cell (______) ____________________________________
Email: ____

If I cannot be reached at the contact information above, I give permission to speak with the following people to inquire about any forwarding phone numbers/address where I may be reached. I also give permission for the person(s) named below to answer questions about my progress since leaving treatment on the follow-up survey to the best of their knowledge.

Name of person/telephone numbers to call in case of emergency. This person may also **pick up or have driver drop off** patient if I cannot be reached.

Name: ____ Relationship: ____________________________________
Phone: Home (______) ________________________________ Cell (______) ____________________________________

Name: ____ Relationship: ____________________________________
Phone: Home (______) ________________________________ Cell (______) ____________________________________

Name: ____ Relationship: ____________________________________
Phone: Home (______) ________________________________ Cell (______) ____________________________________

THIS CONSENT FOR FOLLOW-UP WILL EXPIRE 6 MONTHS POST DISCHARGE FROM TREATMENT UNLESS CANCELLED BY ME.

Patient Name (print): ________________________ Signature: _________________________Date: _____________________

Parent/Guardian Name (print): __________________________ Signature: ___________________ Date: _________________

I do not wish to provide any follow-up information concerning my post treatment behavior.

Patient Name (print): ________________________ Signature: _________________________Date: _____________________

Parent/Guardian Name (print): __________________________ Signature: ___________________ Date: _________________

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Patient Chart # ____________________

Request & Release of Information

Release Agency/Organization/Person Name: ____
Address:____
City: ____ State: ________ Zip: ____________________
Phone: _______________________________________ Fax: _____________________________________

I hereby authorize the person(s) and/or agency/organization along with Intecelle, Inc. to engage in sharing either verbally or written communication regarding my records and/or treatment information as listed below. I understand that the information concerning my psychiatric, psychological, diagnosis, drug, and alcohol abuse will be released or requested. I also understand that my medical and/or mental health information contains treatment notes, diagnosis and/or test results of HIV/AIDS or other related conditions; these records shall also be released. This consent will automatically expire 90 days after the date signed.

RECORDS TO BE RELEASED (Intecelle)

____ Treatment Plan

____ Progress Notes/ Reports

____ Health/Medical Records

____ Educational Reports

____ Discharge Summaries

____ Psychiatric/Psychological

____ Social/Developmental History

____ Verbal Communication

____ Other ____________________

RECORDS TO BE RELEASED (OTHER AGENCY)

____ Treatment Plan

____ Progress Notes/ Reports

____ Health/Medical Records

____ Educational Reports

____ Discharge Summaries

____ Psychiatric/Psychological

____ Social/Developmental History

____ Verbal Communication

____ Other ____________________

For the purpose of **SERVICE COORDINATION**: Information will not be discussed to any other party/agency without prior written consent of the client and/or parent/legal guardian. This release is protected under State and Federal confidentiality regulations Title 42 (CFR) Part 2 and FS 90.503. A copy is valid in lieu of the original

Patient Name (print): ______________________ Signature: _______________________Date: ______________________

Parent/Guardian Name (print): ________________________ Signature: ______________________ Date: _______________

Witness Name (print): ______________________ Signature: _______________________ Date: ______________________

*I hereby **REVOKE** my permission to disclose information effective ___________________. I understand that this does not affect information released prior to this date.*

Patient or Parent/Guardian Signature: ____ Date:___________________

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Patient Chart # ____________________

TREATMENT PLAN/ PLAN REVIEW/ DISCHARGE PLAN

Patient Name:____________________________D.O.B.:___________________Est. Discharge Date: _______________

After Care Plan: Patient/Family's expectation concerning treatment outcome, community resource referrals, educational activities, and/or other support services to withstand improvements achieved during treatment:

____

____

____

Responsible Behavioral Staff: ____

I, the patient or the patient's guardian reviewed and agreed to participate in the interventions identified in the Individualized Treatment Plan that is in Intecelle Inc. electronic records system (Open EMR). **I HAVE ALSO RECEIVED A COPY OF SAID TREATMENT PLAN FOR MY RECORDS.**

Furthermore, the services can be expected to improve the client's condition and functional level which cannot be improved in a less restrictive or less costly level of care.

Plan Effective Date:__________

☐ **Patient** ☐ **Guardian Signature:**____**Date:** _______________

Clinician Signature & Credentials:____**Date:** _______________

Supervisor/Reviewer Signature & Credentials:______________________________________**Date:** _______________

Addt'l Team Mbr. Signature & Credentials:____**Date:** ________________

As the treating psychiatrist and/or licensed clinician for the above referenced patient; I hereby certify this patient meets the eligibility criteria and needs the behavioral health services as outlined in the Individualized Treatment Plan.

I additionally certify the specific treatment services herein prescribed for the patient in this Treatment Plan is medically necessary and appropriate to the patient diagnosis and treatment will start from the date of admission. Review of this treatment plan will occur at a minimum of every six (6) months.

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