



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: _____

CHILD / ADOLESCENT INTAKE FORM

 Child's 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

Name of School: _____ Last Grade Completed: _____

Parent Information

Parent/Legal Guardian: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home (_____) _____ Cell (_____) _____

Email: _____

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: _____

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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 family (DCFS, Child Welfare, Courts, etc.)?

History of Problem

Please describe what concerns you have regarding your child:

How long has the problem existed? _____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

What attempts have been made to resolve the difficulties? _____

 Explain how you would like for Intecelle Inc. to help you and your child:

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	Stomach Aches
Frustration	Head Aches	Bed Wetting
Suicidal Thoughts	Phobias	Sleep Problems
Inability to Concentrate	Obsessive Thoughts	Tension and Anxiety
Panic Attacks	Memory Problems	Compulsive Behaviors
Hyperactivity	Poor Grades	School Suspension
Always in Trouble	Stubborn	Others

 List any other problems or feelings not identified above:



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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 the 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 if 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: _____

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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Notice of Privacy Practices
HIPAA: Acknowledgement of Receipt

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 Inc. 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 Inc. 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: _____

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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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: _____



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: _____

Add'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.