Compass Counseling Services, LLC

Helping You Towards A Better Direction

ORLANDO OFFICE
1400 North Semoran Blvd. Suite E Orlando, Fl 32807
Phone: 407-823– 8421 Fax: 407-823-8195

KISSIMMEE OFFICE
201 Ruby Ave, Suite A, Kissimmee, Fl. 34741
Phone: 407-933-1847Fax:407-933-1849

Confidential Patient Intake Form

PATIENT DEMOGRAPHICS

Patient's Full Name_____ Preferred Name: _____

Patient's D.O.B.: _____ Age: _____ Sex: ( ) Male ( ) Female

Social Security #: _____ Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Street Address: _____ Apt/Suite #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ ( ) May we leave a message here: ( ) Yes ( ) No

Mobile Phone: _____ ( ) May we leave a message here: ( ) Yes ( ) No

Work Phone: _____ ( ) May we leave a message here: ( ) Yes ( ) No

Email Address: _____ ( ) May we send a message here: ( ) Yes ( ) No

Referred by: _____

PRIMARY CARE PROVIDER- must provide

Physician's Name: _____ Office phone #: _____

Street address: _____

City: _____ State: _____ Zip: _____

PSYCHIATRIST

Psychiatrist's Name: _____ Office phone #: _____

Street address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

PRIMARY PARTY INFORMATION (Please complete all areas in this section regarding the primary insurance holder.)

Primary Policy Holder's Name: _____ D.O.B.: _____

Social Security #: _____ Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other

Street Address: _____ Apt/Suite#: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

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RESPONSIBLE PARTY AGREEMENT

Insurance Company Name: _____ Insurance phone # _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Policy/ID#: _____ Insurance Group #: _____

I certify that the above information is true and correct. I agree to take responsibility for the any amounts not covered by this insurance, including copayments and deductibles which are due for any and all services rendered by Compass Counseling Service, LLC.

_____

Patient/Parent/Guardian/Guarantor Signature Date

_____

Patient Name (Print) D.O.B.

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INFORMED CONSENT FOR TREATMENT

_____ I hereby voluntarily consent to enter mental health treatment with Compass Counseling Services, LLC for myself and/or minor child.

_____ I understand that all information disclosed during the course of therapy will be held in confidence with the exception of intervention with threats of harm to myself or others, allegations of child abuse or neglect and/or court ordered disclosures. I understand that ***CCS*** has a legal and ethical obligation to disclose this information and will make every effort to discuss this with me should the need arise.

_____ I understand that all information will be held in the strictest confidence and will not be released to any one without my prior specific written permission. (Please see the Privacy Notice)

_____ I understand that I will expect to be an active participant in my treatment. I acknowledge that there is never a guarantee in the outcome of my therapy and may withdraw from treatment whenever I desire. I acknowledge that all my records are property of ***CCS***.

_____ I understand that payment of co-pays, deductibles and specimen collection related to services are my responsibility and I will notify the office prior to my appointment if payment assistance is needed.

_____ I understand that I will be expected to notify the office of the need to reschedule an appointment at least 24 hours in advance. I will commit myself to keeping my appointments as scheduled.

_____ I understand that as a parent, I am responsible for my child while attending an appointment at ***CCS***. Staff at ***CCS*** will not provide child care.

_____ I understand that failure to cancel an appointment or not showing up for 3 consecutive sessions may result in permanent removal from the schedule.

_____ I have received a copy of the Office Policies and Procedures and agree to abide by these policies and procedures.

_____To extent that my records contains information regarding AIDS, or HIV including for example a test for the presence of HIV antibodies or antigens, regardless of whether (1) this test is performed or reported and (2) the test are positive or negative, I specially authorize release of such information.

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PSYCHIATRIC CARE ONLY

_____ I understand that in order initiate and to continue my Psychiatric Treatment at ***CCS***, I should comply with the attached Urine Drug Screen (UDS) policy of the Institution.

_____ As a guardian of a minor, I understand that prior to my child being seen for Psychiatric Treatment, he/she should: a) undergo an Initial Intake assessment by a designated Psychotherapist at ***CCS***; b) my child should engage and continue to be on Psychotherapy Treatment as part of his/her Psychiatric Care Treatment Plan and c) my child should comply with the UDS policy as well.

_____ As a guardian of a minor, I understand that in case of a positive UDS, my child would be reschedule to see the Psychiatrist after 30 days and will be requested to submit another urine sample as part of our UDS policy.

_____

Patient Name Signature (Parent/Legal Guardian Date

_____

Witness Date

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ASSIGNMENT OF HEALTHCARE BENEFITS

_____ D.O.B. _____/_____/_____
Patient's Name / person responsible if minor child (Please Print)

I hereby authorize **Compass Counseling Services, LLC**, to bill my health insurance company or its representative for any and all services that I receive. I further authorize my health insurance company or its representative to make direct payment of benefits to **CCS** or its providers under the terms of and conditions of my health care contract. In accordance with my health care contract, **I understand that I am ultimately responsible for payment of all services**. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. **I will be held liable for any care provided to me, to my minor/child, or to the Patient that I am legally responsible that are not covered by my insurance company and not contractually excluded from eligibility for payment (including co-pays, co-insurances, specimen collection, and deductibles)**.

In addition, I authorize the appropriate staff at **CCS** to fill out any and all necessary paperwork or electronic claims required by my insurance carrier or managed care company, including but not limited to: treatment plans, insurance claim forms and termination of care information. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

I affirm that I have read or have had read to me, understand, and agree to above authorizations.

_____
Patient's Name (Print)

_____ _____
Signature: if Patient is a minor parent or legal guardian Date

_____ _____
Witness Date

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ONMIBUS HIPPA EFFECTIVE SEPTEMBER 23, 2013

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

_____ hereby acknowledge that I have review and received a copy of Compass Counseling Services, LLC *Notice of Privacy Practices* for protected health information.

- Showing the patient the Notice of Privacy Practices posted in our office.
- Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- Asking the patient to sign this Acknowledgement form.

I also understand that if I have any questions or complaints, I may contact: Adriana Lopez - Office Manager (407)-823-8421

You may also contact the U.S. Department and Health and Human Services with any concerns regarding our privacy and security policies. Please contact our office for information on how to contact U.S. Department of Health and Human Services.

Name of Patient: _____ Date: ___/___/____
Print Name

Name of Patient: _____ DOB: ___/____/____
Signature (IF NOT THE PATIENT STATE RELATIONSHIP)

ONLY FOR OFFICE PERSONNEL USE

Documentation of Good Faith Effort to Obtain Written Acknowledgement
I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information.

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- ☐ The patient refused to sign this form.
- ☐ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ☐ Other (explain in detail)_____

_____

_____

Personnel (staff) Representative: _____ DATE: ___/___/____

Notes: This written Acknowledgement must be completed no later than the first date health care services or treatments are provided to the patient. This Acknowledgement must be retained in the patient's permanent record.

Witness: _____

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HEALTH CARE COORDINATION FORM

Re: _____, identified patient has been seen at Compass Counseling Services, LLC. We are requesting information from you at this time and would like to have this release of information in your records so that our treatment efforts can be coordinated as necessary. Please contact us at the Orlando office (407) 823-8421 or at the Kissimmee office at (407) 933-1847 if additional information is needed.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

_____ **I hereby refuse to give authorization for any release of information**

I hereby authorize the release of all medical, chemical dependency and mental health information necessary to coordinate the treatment I am receiving from the following providers:

_____
Primary Care Physician Name, Phone & Address

_____
Psychiatrist Name, Phone & Address

_____
Other

Disclosure may include the following **verbal or written information**: (check all that apply)

___Face sheet ___History & physical ___Laboratory/diagnostic testing results
___School information ___Discharge summary ___Medication records ___Behavioral health/psychological consult ___Psychological evaluation/testing results ___ER record report ___Psychiatric evaluation ___Psychosocial assessment ___Other ___Substance abuse treatment record ___Summary of treatment records & contact dates

I understand authorizing the disclosure of information between my treatment providers is voluntary. This authorization becomes effective on the date signed and may be revoked by me at any time. If not earlier revoked, this authorization shall terminate automatically one year from today's date. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the information authorized by this release will be provided to the authorized recipients only and that these recipients are prohibited from further disclosure without my specific written consent. The information to be released may include my medical and psychiatric history, current condition, test results, diagnosis, medication and treatment plan. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature of Patient or Legal Guardian: _____

Witness Signature_____

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AFTER HOURS RECOMMENDATION FOR EMERGENCIES

If you believe that you or your child or legal dependent is in immediate danger of self harm or may present an immediate danger to others, please Call 911 immediately.

If the danger is not immediate, please transport yourself or the child to your local emergency room or Community Mental Health Center/Crisis Centers for immediate assessment.

CRISIS CENTERS:

ORANGE COUNTY: University Behavioral Center

ORANGE COUNTY - Lakeside Behavioral Care – (407) 875-3700

SEMINOLE COUNTY – Seminole Community Mental Health – (407) 323-4357

BREVARD COUNTY – Circles of Care – (321) 722-5200

OSCEOLA COUNTY – Park Place Behavioral Health – (407) 846-0023

I have read and understand the above information.

_____

Patient Name Date

_____

Patient/Parent/Guardian Signature Date

_____

Witness Signature Date

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URINE DRUGSCREEN POLICY

☐ Routine and urine drug screening (UDS) has become a standard of care in managing patients.

☐ All new patients should have UDS with confirmation routinely.

☐ UDS will be a requirement for treatment to every "established" adult patient (18 ears old and older) if:

a) The patient tested positive for an illicit or undisclosed controlled substance on the day of the first visit;

b) The patient was started/continued on controlled substances on the first visit;

c) Active chemical dependency/dual diagnosis or illicit substances abuse/recreational use is endorsed or documented by the time of the Psychiatric Evaluation;

d) At any time according to clinical judgment of the Compass Counseling Psychiatric or Psychotherapist.

A negative UDS plus confirmation will be a requirement for a Psychiatric Evaluation and Psychotropic medication management in every minor (less than 18 years old) **WITH NO EXCEPTIONS.**

A negative UDS and confirmation is a requirement for prescriptions of **CONTROLLED SUBSTANCES** for 18 years or older with no exceptions.

Print Name: _____ Date: _____

_____

Signature (If not patient or patient state relationship)

Witness: _____ Date: _____

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NOTIFICATION OF POLICY CHANGES — EFFECTIVE July 1, 2015

LATE APPOINTMENT CANCELLATION & NO-SHOW PROCEDURES: (please Initial)

_____Patient, Parent, Or Guardian are expected to attend all scheduled appointment as agreed upon with their primary Psychotherapist and/or Psychiatrist.

_____A missed or cancelled appointment is costly to the practice and to the other individuals who are in need of available services.

_____Patient who fail to show for their appointments and/or who do not notify the practice *24 hours (or more) in advance* of a planned absence, will be charge **a TWENTY FIVE DOLLAR ($25) FEE.**

_____As insurance does not pay for these appointments; the patient/guarantor is responsible.

_____Three canceled and/or missed appointments could result in being discharged from care.

_____If patient is discharged he/she will receive a 30 day notification letter along with a list of possible referrals. Purpose of notification is to provide enough time for patient to access another service provider. Copies of all correspondence are to be placed in the patient's medical record.

_____If a patient arrives 15 minutes after the appointed hour, it will be necessary to reschedule the appointment.

PATIENT ACKNOWLEDGEMENT:
I have reviewed the above policy change and understand the procedures regarding late cancellations or no-show.

_____

Name (please print) Date

_____

Signature (if not patient state relationship)

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RIGHTS AND RESPONSIBILITIES AS A PATIENT OF COMPASS COUNSELING SERVICES, LLC

Welcome to Compass Counseling Services, LLC. We hope that we can give you the kind of support and help that you are looking for.

When you receive services from CCS you have the right to:

- **Receive high-quality service**
- **Be treated with respect and courtesy**
- **Have your information kept private and confidential except as described in CCS *privacy statement.***
- **Be listened to and have staff work with you to make a plan to address your concerns and needs.**
- **Receive service in offices that are safe, clean and accessible.**
- **Get information and support to help you make decisions to improve your situation.**
- **Be served without discrimination.**
- **Discuss your service with staff to identify if it is working for you and express any questions or complaints that you may have.**
- **Request a change of provider member if there is another provider available who can address your issues and your request is reasonable -- you should know that discriminatory requests will not be considered.**

This is what we ask from you:

- **Treat the staff and others at CCS with courtesy and respect.**
- **Let CCS know 24 hours before if you can not come to an appointment. Please refer to CCS's policy on late cancellation/No shows.**

_____ _____

Patient Signature and/or Legal Guardian if minor **Date**

_____

Witness