Village Counseling Center

HELP AND HOPE FOR CHILDREN AND FAMILIES

CLIENT INFORMATION FORM

Client Information

Date

Last Name		First Name	
DOB		Gender	
Address			
City/State/Zip		County	
Primary Phone		Email Address	
OK to leave Message	☐ Yes ☐ No	OK to Email	☐ Yes ☐ No

Detailed reasons for Treatment/ Services

Caregiver Information (if client is a minor)

Last Name		First Name	
Primary Phone		Emergency Phone	
Relationship		OK to leave Message	☐ Yes ☐ No

Currently Living In Home

Name	Age	Relationship to Client

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Within the PAST 3 MONTHS (client)

☐ Headaches	☐ Over/Under Eating	☐ Sleep Problems
☐ Shyness	☐ Dizziness	☐ Loneliness
☐ Anxiety	☐ Stress	☐ Anger
☐ No Appetite	☐ Nightmares	☐ Divorce/Break Up
☐ Bathroom Problems	☐ Legal Matters	☐ Drug/Alcohol Issues
☐ Nervousness	☐ School/Work Issues	☐ Suicidal Behavior/Attempt
☐ Sexually Related Issues	☐ Family Stress/Arguments	☐ Temper/Outbursts
☐ Mood Swings	☐ Fearful	☐ Crying/Tearful
☐ Flashbacks/Bad Memories	☐ Abuse	☐ Financial Stress
☐ Depression	☐ Recent Move	☐ Unmotivated
☐ Argumentative	☐ Weight Loss/Gain	☐ Self-Harm (ex. cutting)
☐ Lying/Stealing/Destructive	☐ Parenting Issues	☐ Unable to Focus
☐ Recent DCF Involvement	☐ Aches and Pains	☐ Hyperactive
☐ Self-Control Issues	☐ Family Death/Loss	☐ Recent Arrest/Charge

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CLIENT RIGHTS AND RESPONSIBILITIES & HIPAA ACKNOWLEDGEMENT

Client Information

Last Name _____ First Name _____

DOB _____ Soc. Sec. # _____

Legal Guardian *(If client is a minor)*

Last Name _____ First Name _____

DOB _____ Relationship _____

I acknowledge that I was provided the opportunity to review the **Village Counseling Center Policies and Practices to Protect the Privacy of Your Health Information (HIPAA Notice)** and **VCC Client Rights and Responsibilities Forms**.

I understand that I can always ask questions about my treatment rights, responsibilities and confidentiality. I can also review and/or obtain a personal copy of either form available in the front office or at the VCC Website (www.villagecounselingcenter.net)

_____ _____

Client Signature Date

_____ _____

Signature of Parent, Legal Guardian (If client is a minor) Date

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FEE AGREEMENT

Client Information

Last Name _____ First Name _____

OFFICE HOURS: We are generally open from 8:30 a.m. to 5:00 p.m., Monday through Friday except major holidays. Limited evening appointments are available depending on your Therapist. If you call at a time when office staff is not available, please leave a non-emergency message at **(352) 373-8189**. You can also email the main office at info@villagecounselingcenter.net or email/call/text your Therapist directly.

FEES: Fees are based on the services provided. A list of all VCC Services and Fees is available at the Front Desk. A Sliding Scale/Discounted fee is available for clients who meet specified criteria. If you wish to explore this possibility, please speak directly with your Therapist/Assessor. You will be required to provide proof of income (ex. Tax Return, paystub) in order to receive a discounted fee.

PAYMENTS: Full payment is expected at the time of service. If needed, we can provide you with a receipt which you can attach to a letter or claim form to submit to your insurance company for reimbursement. Failure to pay for services may result is your services being suspended and/or monthly late fees until your account is paid in full. If the decision is made to submit your account to a collection agency, you will be responsible for any attorney and/or other fees incurred in collecting your overdue balance.

CANCELATIONS AND/OR FAILED APPOINTMENTS: If you are unable to keep your scheduled appointment, please email/call/text your Therapist directly or call the office at least 24 hours before your appointment time. **If you fail to cancel your appointment at least 24 hours in advance you may be charged the full fee for the missed session.** Clients who cancel and/or miss three (3) or more sessions may be unsuccessfully discharged from treatment.

RETURNED CHECKS/PAYMENTS: Clients/Guardians are responsible for any bank fees charged to VCC due to checks returned as a result of insufficient funds. You may be charged an additional service fee of $50.00 per check. You are also still responsible for paying the original fee for the service provided.

CLIENT OR LEGAL GUARDIAN:
I understand and agree to all of the information and terms listed above.

Signature: _____ **Date:** _____

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CONSENT FOR ASSESSMENT and/or TREATMENT

Client's Full Name: _____ **Date of Birth:** _____

Regarding services at the Village Counseling Center (VCC), I understand that:

1. My participation in any service is voluntary and my consent and/or participation may be withdrawn at my discretion.
2. Although there may be a court order for me, or my child to participate in treatment, my participation is voluntary.
3. I have the right to understand the purpose and goals of my treatment and can ask questions at any time.
4. My confidentiality will always be protected, and personal information will not be shared with others without my consent (e.g., Release of Information Form).
5. There are legal limitations on confidentiality that must be observed by all mental health professionals. Specifically, VCC has a legal responsibility for assessing risks associated with suicidal and/or homicidal ideation and depending on the risk VCC has a duty to protect the client and/or others who might be in harm's way. This may include helping a client attain a safe environment by assisting with emergency mental health services, calling 911 and/or contacting law enforcement.
6. Services will be provided within the scope of your provider's licensure, certification, and training. I will be informed if my mental health needs are beyond the scope of my provider's qualifications.
7. If the client is a minor, all legal guardians must consent to services and sign a "Consent for Assessment and/or Treatment" Form regardless of court sanctions, orders, custody arrangements, etc.
8. Counseling and behavioral health treatment is not an exact science and active and appropriate participation is necessary for best results. No specific treatment recommendations and/or outcomes can be promised or guaranteed.
9. VCC does not provide emergency or afterhours services and I should contact a crisis line, 911, mental health facility and/or hospital in a life threatening or emergency situation.
10. My services may be discontinued at the discretion of my provider if I am inappropriate, destructive or unlawful and if I do not participate appropriately or attend scheduled appointments.
11. I may not record (e.g., audio, video, etc.) any VCC assessment and treatment services without my providers consent and that doing so may result in criminal charges as well as immediate discharge from treatment.
12. I can obtain a copy of this form as well as the VCC Client Rights and Responsibilities and VCC HIPPA Notice at any time by request or at www.villagecounselingcenter.net.

I, or as the legal guardian of the youth named above, agree with all the conditions above and grant the Village Counseling Center (VCC) permission to assess and/or treat myself or the client named above.

Printed Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

3919 W Newberry Road, Suite 5 Gainesville FL 32607 (352) 373-8189 info@villagecounselingcenter.net

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COMPREHENSIVE AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Client Name: _____ **Date of Birth:** _____

Social Security #: _____ **County of Residence:** _____

This authorizes the Village Counseling Center, Staff and Independent Practitioners to release and/or receive general medical, psychiatric/psychological, assessment and/or school information from my client records in accordance with Florida Statues and Federal Administrative Rules and Regulations. The Village Counseling Center, Staff and Independent Practitioners are all released from any legal liability that may arise from the release/receipt of the information requested.

Agencies and parties to and from authorization pertain: ***(Please mark all boxes that apply)***

- ☐ Department of Children and Families (DCF)
- ☐ Department of Juvenile Justice (DJJ)
- ☐ Guardian ad Litem Program (GAL)
- ☐ Meridian Behavioral Healthcare, Inc.
- ☐ Partnership for Strong Families (PSF)
- ☐ Public Defender's Office
- ☐ Office of the State Attorney
- ☐ Alachua County School Board/Program
- ☐ Mental Health Provider/s: _____
- ☐ Extended Family Member/s: _____
- ☐ Foster Parent/s: _____
- ☐ Non-Relative Placement: _____
- ☐ Medical Provider/s: _____
- ☐ School/s: (Include county) _____
- ☐ OTHER/S: (Please list) _____

Information to be released is as follows: ***(Please mark all that apply)***

- ☐ History, Physical, Lab Work
- ☐ Legal/Court Records
- ☐ Psychiatric/Psychological Reports
- ☐ Educations and School Records
- ☐ Social History
- ☐ Treatment and/or Substance Abuse Records

This authorization will be valid for 365 days from the date specified below or until the client identified above is discharged from treatment, whichever is latest. I understand that I have the right to terminate this authorization at any time by sending a written statement indicating such to the Village Counseling Center, except to the extent that action has already been taken in accordance with the above authorization. This authorization will be valid for all methods of communication (e.g., phone, fax, email, etc.). **Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further release or re-disclosure is strictly prohibited.** **REV. 1/29/19**

Client or Parent/Legal Guardian Signature	Printed Name	Date
Witness Signature	Witness Printed Name	Date