

CLIENT INFORMATION FORM

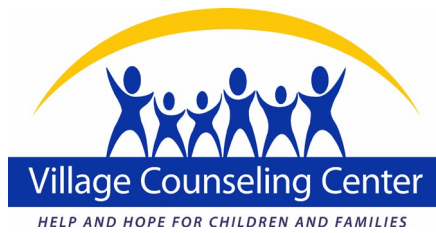
Client Information		Date
Last Name _____	First Name _____	
DOB _____	Gender _____	
Address _____		
City/State/Zip _____	County _____	
Primary Phone _____	Email Address _____	
OK to leave Message <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to Email <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No

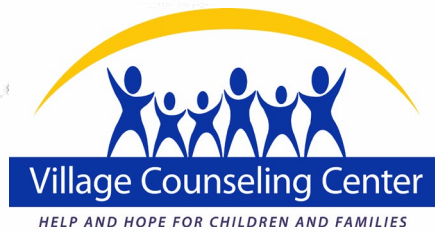
Currently Living In Home

Name	Age	Relationship to Client



Within the PAST 3 MONTHS (client)

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



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**.

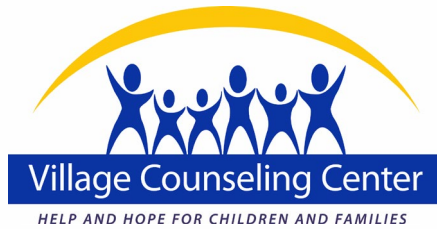
I understand that I can always ask questions about my treatment rights, responsibilities and confidentiality. I can also review and/or obtain a personal copy of either form available in the front office or at the VCC Website (www.villagecounselingcenter.net)

Client Signature

Date

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

Date



FEE AGREEMENT

Client Information

Last Name _____	First Name _____
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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 in 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.

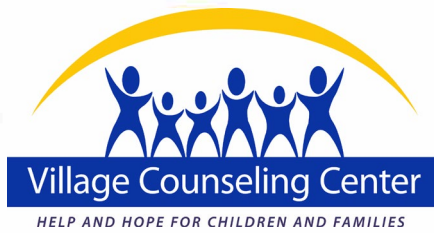
RETURNED CHECKS/PAYMENTS: Clients/Guardians are responsible for any bank fees charged to VCC due to checks returned as a result of insufficient funds. You may be charged an additional service fee of \$50.00 per check. You are also still responsible for paying the original fee for the service provided.

CLIENT OR LEGAL GUARDIAN:

I understand and agree to all of the information and terms listed above.

Signature: _____

Date: _____



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:** _____

Rev 10/2018

