HISPANIC FAMILY COUNSELING, INC.
Orange/Seminole/Osceola/Brevard:
Main Office: 6900 S. Orange Blossom Trail, Suite 402 • Orlando, FL. 32809
Phone (407) 382-9079 • Fax (407) 964-1274
referrals@hispafam.com • www.hispafam.com

RECORD #

INTAKE INFORMATION

Client Demographic Information:

Name:____ S.S : __ __ __ - __ __ - __ __ __ __ Birth Date:__________________ Age: ______
Parents/Caregivers Names:____ Relationship: ___________________________
Address:____ City:____________________ County: _______________
State: ______ Zip:___________________ Phone: ________________________________ Other phone: _____________________________
Email:____
Bilingual Required: □ Yes □ No Language: __________________ Religion: ________________ Reason for services: ________________
Sex: □ F □ M Legal Status: □ Minor in parent/guardian Custody □ Minor in State Custody □ Competent Adult □ Incompetent Adult

Marital Status:	**Disability:**	**Race:**	**Ethnic:**		
□ Never Married	□ Developmental Disability	□ White	□ Puerto Rican	□ Venezuelan	□ Nicaraguan
□ Married	□ Physical Disability	□ Black	□ Mexican	□ Colombian	□ Peruvian
□Widowed	□ Non-Ambulatory	□ Nat. Amer. Indian	□ Cuban	□ Honduran	□ Costa Rican
□ Divorced	□ Visual Impairment	□ Asian	□ Spanish/Latino	□ Panama	□ Salvadorian
□ Separated	□ Hearing Impairment	□ Pacific Islander	□ Haitian	□ Dominican	□ Argentinean
□ Unknown	□ Psychiatric Disability (SSI)	□ Multi-racial	□ Guatemalan	□ Brazilian	□ Uruguayan
	□ No disability		□ Ecuadorean	□ Chilean	□ Paraguayan
			□ Bolivian	□ Other: __________	

Other Current Services

□ No Current Services
□ Primary Care Physician Name/Facility: ____ Phone: ______________ Address: __________________________
□ Mental Health/ Behavioral Health Name/Agency: ____ Phone: ___________________ Reason: _____________
□ Psychiatric/Medication Name/Agency: ____ Phone: ____________________ Medication:__________________
□ Probation Officer Name/Agency: ____ Phone:___________________ Charges:______________________
□ Other: __________________________ Name/Agency:____ Phone:________________________________

Funding Information (Choose One)

Aetna, AHCA, Ambetter, Amerigroup, Anthem, AvMed, Beacon, Care Plus, Cenpatico, Champus, Children's Medical Services, CHS, Cigna, Corvel, Deveraux, EAP, Florida Health Care, Florida True Health, Freedom, Healthease, Humana, LifeSynch, Magellan, Medicare, Medicaid, Med One, MHnet, Multiplan, Optium, Prestigue, Psychcare, Staywell, Sunshine, Tricare, United Behavioral Health, Value Options, Wellcare.

□ Medicaid # _________________________________ □ Medicare # ____________________________________ Insurance ID # __________________________
□Private Insurance: __________________________________ Copayment Amount: ________ ID#__________________________ Group#___________________
Insurance Phone:_________________ Ins. Address:____
□ Other Insurance:________________________________ □ Self Pay Amount______________

School/Work Information

□ Regular Ed □ EH □ SED □ SLD □ EMH □ TMH □ PMH □ VE □ Autistic □ ESOL □ Other:______________
School: ____ Contact Person: __________________________ Phone:___________________
Address:____
Employer: ____ Time working there: ______________ Phone:________________________
Address: ____

Referral Source Information

Referring Agency: ___________________________________ Person Making Referral: ________________________ Phone: ______________________
Email: _______________________________ Fax: _______________ Reason for Referral: _________________ Services requested:_________________
Referral Source Type (check one):

☐Client self-referred	☐School	☐Addiction Facility (ARF)	☐Law Enforcement
☐Substance Abuse Provider	☐Employer (EAP)	☐Case Mgmt/Referrals/Outreach	☐DCF-ADM
☐Mental Health Provider	☐Family/Friend/Church/Welfare Agency	☐Community Hospital	☐DCF-Foster Care
☐Juvenile Justice	☐Court Order	☐DCF-Protective	☐Other: __________________
☐County Public Health	☐Probation/Parole	☐Physician/Doctor	

Family Composition:

√	Name	Relation	DOB	Sex	Race	Comment

For Office use Only:
Intake date:_______________ Diagnosis: ____________________ Primary Clinician name:_______________________

____ ____________________

Signature Primary Clinician Credentials Date

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Name of Client: ________________________________ **Date of Birth:** ____________ **INTAKE CONSENT**

CONSENT FOR TREATMENT AND TREATMENT LOCATION: I am the legal guardian or I am a competent adult and consent for the above named client to participate in treatment through Hispanic Family Counseling at the following locations:

___YES ___ NO HFC Office: (Choose) Altamonte, Brevard, Kissimmee, Orlando_______________
___YES ___ NO Client Home: ____
___YES ___ NO School: ____
___YES ___ NO Other: ____

I give permission and consent for the identify individuals or organizations to be part in the treatment of the above named client. I acknowledge and understand that the identify persons will have access to confidential information for the intention of assessment and treatment.

Family: ____ spouse/partner; ____ siblings; ____ grandparents;____ parents/foster parents; ____step-parents;
School: ____ teacher; ____ principal; ____ staff; ____ guidance counselor; ____ other

Primary Care Physician: ______________________________ Telephone: __________________

Referral Agency: ____

Other Providers: ____

CONFIDENTIALITY: Any information about you is considered private and will not be shared with anyone without your consent. There are a few exceptions in which we are required to release information about you.

- We are required to report suspicion of child abuse and neglect to the State of Florida.
- We have a duty to warn potential victims if we believe that their lives are in danger.
- We are required to release a copy of records and/or testimony if subpoenaed in court.

FUNDING AUTHORIZATION: I authorize _________________________ (funding agency or resource) to pay for services directly to Hispanic Family Counseling, Inc. Is my obligation to be responsible for the charges that this funding source does not cover. I understand that any confidential information will need to be released to the funding agency or resource in order to process any claim and obtain reimbursement.

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The information on this page has been explained to me. I understand that I may revoke consent for the above at anytime, however, I cannot revoke consent for action that has already been taken. A copy of this release shall be valid as the original.

☐ I received a copy of the Client Rights pamphlet, which describes my rights and responsibilities, including whom to contact for complaints and grievances.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED.

______________________________		______________________________	
Client/Legal Guardian Signature	Date	Witness	Date

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NO SHOW/CANCELLATION POLICY

Client: ____ Birthdate: _______________

Regular attendance at scheduled appointments is very important. Our services will not be effective in helping you if you do not keep your appointments. Irregular attendance, especially a "no show," is also inconvenient and costly for the staff assigned to help you. It is therefore your responsibility to attend all scheduled appointments.

Whenever possible, please notify your assigned clinician at least **24 hours in advance** if you will not be able to keep your scheduled appointment.

CANCELLATION POLICY: If you call your assigned clinician at least an hour before your scheduled appointment, it is considered a "Cancellation," although 24-hour notice is preferred.

1. After the first cancellation, the staff person will call you to reschedule.
2. After two cancellations in a row, the Director will send you a letter explaining that you must call him/her if you desire to continue services.
3. After the third cancellation in a row, services will be terminated.
4. If you cancel three times, with some attendance in between each cancellation, your therapist will discuss with you some possible solutions to the problem of irregular attendance.

NO SHOW POLICY: If you do not call to cancel at least an hour before the scheduled appointment time, it is considered a "No Show."

1. If you fail to notify your assigned clinician prior to a missed in-home session, you will be charged a $25 travel fee to cover the staff cost of traveling to your home for the missed appointment.
2. If you fail to notify your assigned clinician prior to an in-office or in-school session, you may be charged a $25 travel fee if the staff traveled to that location specifically for that session.
3. After the first "No Show," the staff person will call to reschedule the appointment.
4. After the second "No Show," the Director will send you a letter explaining that you must come to the office in person to complete a request to reinstate services if you desire to continue services. In this form, you will be required to renew your commitment to attend sessions or call the staff ahead of time if you need to reschedule.
5. After the third "No Show," your case will be closed.

I understand Hispanic Family Counseling's No Show/Cancellation policy and understand that regular attendance is necessary for treatment to be effective. Therefore, I agree to attend all scheduled sessions. If I cannot keep an appointment, I will call the staff 24 hours in advance to reschedule. If I have an emergency that prevents me from attending, I will call the assigned clinician at least one hour before the appointment to cancel.

______________________________________ ____________________

Client Signature Date

______________________________________ ____________________

Parent/Caregiver Signature Date