JEWISH DAY SCHOOL COUNSELING PROGRAM INTAKE PACKAGE

Jewish Community Services OF SOUTH FLORIDA

JEWISH COMMUNITY SERVICES OF SOUTH FLORIDA

CLIENT INFORMATION FORM (Forma de Informacion del cliente)

Please ✓ appropriate client status: ☐ NEW ☐ PREVIOUS CLIENT	DATE: Fecha	CLIENT ID#

①CLIENT/PERSON BEING SEEN (Cliente / Persona que va a ser atendida)

LAST (Apellido)	FIRST (Nombre)	MIDDLE INITIAL
ADDRESS (Direccion)		APARTMENT #
CITY(Ciudad)	STATE (Estado)	ZIP + 4 (Codigo Postal)
HOME (Casa)( )	WORK (Trabajo)( )	BPR/CELL ( )
SOCIAL SECURITY #		☐MALE (Hombre) ☐FEMALE (Mujer)
DATE OF BIRTH (Fecha de Nacimiento)	AGE (Edad)	RELIGION
EMPLOYER (Empleador)	EMPLOYER ADDRESS (Dir. del Empleador)	
EDUCATION (Educacion)	ETHNICITY/RACE (Raza/Cultura)	OCCUPATION (Ocupacion)
REFUGEE ☐YES (Si) ☐ NO (Refugiado)	MARITAL STATUS: (Estado Civil) ☐MARRIED (Casado(a)) ☐SINGLE (Soltero(a)) ☐DIVORCED (Divorciado(a)) ☐WIDOWED (Viudo(a)) ☐ OTHER (Otro)	
ANNUAL HOUSEHOLD INCOME (Ingreso anual)	WHO REFERRED YOU TO US?(Quien lo refirio a nosotros)	

EMERGENCY CONTACT (Contacto de Emergencia)

NAME (Nombre)	RELATIONSHIP (Relacion)	PHONE (Telefono)( )

(circular uno) (Circle One) ②SECOND ADULT OF HOUSEHOLD OR CHILD'S PARENT / GUARDIAN (Segundo adulto en la casa o Padre / Guardian)

LAST (Apellido)	FIRST (Nombre)	MIDDLE INITIAL
ADDRESS (Direccion)		APARTMENT #
CITY (Ciudad)	STATE (Estado)	ZIP + 4
HOME (Casa) ( )	WORK (Trabajo)( )	BPR/CELL ( )
SOCIAL SECURITY # (seguro social)	DATE OF BIRTH (Fecha de Nacimiento)	☐MALE ☐ FEMALE (Hombre) (Mujer)
MARITAL STATUS (Estado Civil)	ETHNICITY (Cultura)	RELIGION
EDUCATION (Educacion)	EMPLOYER (Empleador)	
EMPLOYER ADDRESS (Dir. del Empleador)		
OCCUPATION (Ocupacion)	RELATIONSHIP TO CLIENT (Relacion al Cliente)	

OTHER HOUSEHOLD MEMBERS (Otros ocupantes de la casa)

NAME (Nombre)	RELATION (Relacion)	DATE OF BIRTH (Dia de Nacimiento)	SEX (Sexo)
③			☐MALE ☐FEMALE
④			☐MALE ☐FEMALE
⑤			☐MALE ☐FEMALE
⑥			☐MALE ☐FEMALE

STAFF USE ONLY (PLEASE PROVIDE CODE NUMBERS-THIS SECTION MUST BE COMPLETED)

THERAPIST	STAFF ID #	LICENSE #	CREDENTIAL
PROGRAM	LOCATION	DIAGNOSIS (S) /	
SERVICE CODE /FEE	SERVICE CODE /FEE	SERVICE CODE /FEE	
SUPERVISOR	STAFF ID #	CREDENTIAL	

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CONSENT FOR MENTAL HEALTH TREATMENT

The following will apply to me and my child while my child is engaged as a client of Jewish Community Services (JCS). The purpose of this statement is to establish guidelines for appropriate treatment, and to facilitate the maximum benefit from treatment.

1. Length of therapy sessions are designed to accommodate the needs of each client.
2. Therapy is a means of causing change. I understand there is a degree of risk involved in causing change to occur. Any risk can be discussed with my child's therapist. The parent/guardian will email the therapist to set an appointment for this.
3. If my child is a danger to him/herself or others, the clinician or designated staff person will call my emergency contact person.
4. Neither my child nor I will bring fire-arms to my sessions.

The following will apply to me as your therapist at Jewish Community Services:

1. JCS will not release information regarding your case outside of JCS **without your written consent**. The limits of confidentiality have been clearly explained including: mandatory reporting to the Florida Department of Children and Families (FDCF) for child or elder abuse; or danger to myself or others.
2. JCS will maintain the highest standards of clinical practice, consistent with the agency's standards, and those of the State of Florida Department of Health.
3. I will advise you of any use of non-traditional therapies that might be used. You have the right to refuse. All risks, benefits and alternatives will be explained to you.

- ***In the event that I choose to text, e-mail or Skype with any staff person at JCS, I do so knowing these forms of electronic communications are not HIPAA protected and knowingly take the risk that it may not be held confidential.***
- ***I have read and fully understand the above statements and give my consent to treatment at Jewish Community Services.***

Student Name Date

Clinician's Signature Date

Parent/Guardian/ Other Signature Date
(Circle one)

Authorization for Use or Disclosure of Protected Health Information

I, ______________________________ authorize Jewish Community Services of South Florida, Inc., their administrative and clinical staff to (check all that apply):

☐ Disclose the following protected health information to: ____

____

☐ Request the following protected health information from: ____

____

☐ The Client has requested this information be used and disclosed but does not wish to specify the purpose.

☐ This protected health information is being used or disclosed for the following purposes:

____

Please send requested records to: (Check one)

☐ **JCS, 18999 Biscayne Blvd., Suite 200, Aventura, FL 33180** Attention: ______________________

☐ **JCS, 333-41st Street, Suite 208-210 Miami Beach, FL 33140 Attention:** ______________________

☐ **JCS, 7000 SW 62nd Avenue, Suite PH-C, South Miami, FL 33143 Attention:** ______________________

☐ **JCS Access, 735 NE 125th Street, North Miami, FL 33161 Attention:** ______________________

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I also understand that if I refuse to sign this authorization I may not be eligible for, or receive research-related treatment or treatment that I have requested for the purpose of disclosure to others.

☐ The use or disclosure requested under this authorization will result in direct or indirect remuneration to **Jewish Community Services of South Florida, Inc.** from a third party. Such as:

1) Any insurer compensation carrier or other agency providing financial assistance for treatment. Information from clinical records may be used by the agency for Health Care Administration, the Department of Children and Families, and the Human Rights Advocacy committees for the purpose of monitoring facility, activity and complaints concerning facilities.

2) Except for the above case, all information that you furnish to JCS will be kept in strictest confidence, as required by Florida law, and will not be shared with any agency or person outside this agency, unless so requested by you.

☐ The use or disclosure requested under this authorization will **not** result in direct or indirect remuneration to **Jewish Community Services of South Florida, Inc.** from a third party.

This authorization shall be in force and effect until termination of treatment (or earlier date) __________ if the client so chooses at which time this authorization to use or disclose this protected health information expires.

I understand that a revocation is not effective to the extent that my therapist and or physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or if my authorization was required for treatment provided by participating in a research study.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Robert Senn, Director, Finance and Accounting
Jewish Community Services of South Florida, Inc.
735 NE 125th St., N. Miami, Florida 33161

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

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MEDICATION LOG

(Update when change of medication occurs or when medication is discontinued)

Client's Name: ______________________________ ID #: ______________________________

Date	Medication / Dose	Physician Name & Telephone Number	Date medication prescribed post intake	Date discontinued

I understand that the above named medication(s) may cause some side effects. I have discussed these with my doctor(s).

______________________________ ______________________________

Client's Signature Date Clinician's Signature Date

____

Parent/ Guardian/ Other Date

Revised August 2015