



Intake Consents & Orientation

Client Name: _____ Date of Birth: _____

For Minor Clients in Parents' Custody:

I have sole responsibility to consent to treatment for the minor client or
The minor client has another parent who must consent to treatment as well and can be contact at:

Name: _____ Number: _____

HEALTH & SAFETY: I received a copy of the *Health & Safety* pamphlet, and it was explained to me, including wellness education; the agency's policies on tobacco, drugs, alcohol, prescription medications, weapons, abuse reporting, agency's responsibility to respond to client risk of danger to self/others; the agency's emergency procedures; and after hours crisis/emergency phone numbers.

CLIENT RIGHTS: I received a copy of the *Client Rights* pamphlet, and it was explained to me, including what to expect in the assessment, treatment planning, treatment & discharge process; client rights & responsibilities; agency rights & responsibilities; grievance process; treatment philosophy; Primary Clinician name/phone number; and office hours/phone number.

LIMITS TO CONFIDENTIALITY/PRIVACY: I understand that all information about the above-named client is considered private and will not be shared with anyone without my consent, except under the following circumstances:

- A Core Connection is required to report suspicion of child/elder/disabled adults abuse & neglect.
- A Core Connection is required to release information for the purpose of abuse/neglect investigations.
- A Core Connection is allowed to warn potential victims if we believe that their lives are in danger.
- A Core Connection is required to release a copy of records and/or testimony if subpoenaed in court.

Even with your consent, A Core Connection will share only the information that is necessary for assessment, coordination of treatment, notification to those responsible for mandated treatment, or other specified purposes as described in the *PCP Notification* and *Release of Information* forms

STATEMENT OF AUTHORITY TO CONSENT: I certify that I have the legal authority to consent to mental health treatment, release of information, and all legal issues involving the above-named client. If my status as legal guardian should change, I will immediately notify A Core Connection of the name, address, and telephone number of the person who has assumed guardianship of the above-named client.

CONSENT FOR TREATMENT AND TREATMENT LOCATION: I consent for the above-named client to participate in mental health assessment and treatment through A Core Connection, including sharing relevant confidential information with those involved in services:

School Personnel, such as teachers, counselors, behavior specialists, principal, etc.

Other Family Members, such as step-parents, siblings, grandparents, foster parents, etc.

Other Case Management or Treatment Professionals: _____

FUNDING AUTHORIZATION: I authorize A Core Connection to release relevant confidential information to my current funding source in order to process claims, obtain reimbursement, and comply with the funding source's auditing requirements.

**I understand that I will be responsible for any charges that this funding source does not cover, including any services provided after my insurance has lapsed, fees described on the *Copayment Agreement*, and fees described in the *No Show/Cancellation Policy*.

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.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED.

Client (if adult) or Parent / Legal Guardian Signature

Date

Relationship to client



Telehealth Consent

Client Name: _____ Date of Birth: _____

Telehealth Consent

I hereby consent to participate in telehealth services with, A Core Connection Services and Consulting, as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telehealth health:

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is required.
- 6) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within two minutes, please call me to discuss other options.
- 7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. Emergency Protocols I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED.

Client (if adult) or Parent /Legal Guardian Signature (if minor)

Date

Relationship to client

Client: _____ Date of Birth: _____

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.

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 \$20 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 \$20 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 office will send you a letter notifying you that services have been suspended and that you are required to pay the travel fees for both missed sessions in order to reinstate services.
5. After the third “No Show,” your case will be closed.

If these services are mandated or court-ordered, the person responsible for monitoring compliance with the mandate (e.g., dependency case manager, probation officer) will be notified of repeated cancellations/no shows and suspension or termination of services.

I understand A Core Connection’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 (if adult) or Parent /Legal Guardian Signature (if minor)

Date

Relationship to client



PCP Notification Form

Client Name: _____ Date of Birth: _____

This client's Primary Care Physician is as follows (Please complete the PCP Name and fax number):

PCP Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email address: _____

Purpose of Release: This document serves as notification to the Primary Care Physician that counseling and/or behavior analysis services are being provided by

A Core Connection Services and Consulting, LLC.

Acknowledgement: By signing below, I authorize A Core Connection to release a copy of this document to the PCP named above. I further authorize exchange of confidential information between the PCP and A Core Connection for the purpose of coordination of care. Contact information for A Core Connection is as follows:

2135 West State Road 434
Longwood, FL 32779

2748 South Ferncreek Ave
Orlando, FL 32806

2139 West State Road 434
Suite 102
Longwood, FL 32779

(407) 789-CORE Office (407) 612-2359 Fax

FOR NOTIFICATION PURPOSES ONLY -- DO NOT SEND RECORDS

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from A Core Connection.
- I understand that I may revoke this authorization in writing at any time, however I cannot revoke authorization for action that has already been taken.
- A copy of this release shall be valid as the original.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

Client (if adult) or Parent /Legal Guardian Signature (if minor)

Date

Relationship to client



Consent to Release Information

Client Name: _____ Date of Birth: _____

I authorize A Core Connection Services and Consulting located at:

2135 West State Road 434
Longwood, FL 32779

2748 South Ferncreek Ave
Orlando, FL 32806

2139 West State Road 434 Suite 102
Longwood, FL 32779

to exchange confidential information concerning the above-named client with the following:

Agency/Contact: _____
Mailing Address: _____
City, State, Zip: _____
Phone/Fax: _____
Email: _____

I authorize:

Informal communication regarding all client information between both parties.

AND/OR

Copies of the following documents to be mailed/faxed to the agency listed above

Copies of the following documents to be mailed/faxed to A Core Connection Services & Consulting

Limited verbal communication (no copies) related only to the following records

(Check which documents are authorized to be released)

- | | |
|----------------------------|--------------------------|
| ABA Assessment | Mental Health Assessment |
| ABA Reassessment | Behavioral Program |
| Medical History & Physical | Progress Summary |
| Discharge Review | Other: _____ |

Purpose of Release:

Assessment Treatment Coordination Other, specify: _____
Notification of compliance with court-ordered treatment (e.g., DCF, DJJ)

- I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from A Core Connection Services & Consulting.
- I understand that if I am court-ordered into treatment and refuse to allow A Core Connection Services & Consulting to share information with those responsible for monitoring my compliance with mandated treatment, this may result in negative consequences imposed by the court.
- I understand that I may revoke this authorization in writing at any time, however I cannot revoke authorization for action that has already been taken.
- A copy of this release shall be valid as the original.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

Client (if adult)/Legal Guardian (if minor) Signature

Date

Relationship to client

This pamphlet is to let you know what to expect from the services you and your child will be receiving from A Core Connection. It will also tell you what your rights are and what you need to do to make treatment a success.

What to Expect:

1. Our focus is on helping the whole family, not just you, so your family should plan to participate in family sessions.
2. Sessions are scheduled on a regular basis, 1-2 times per week, depending on the seriousness of the issues.
3. Treatment is usually about 6 months, but it can be shorter or longer depending on you and your family's motivation and progress.
4. You may be called by our office for a brief satisfaction survey at some point during treatment; your feedback is important to us.
5. You will meet with a Licensed Clinician to do the initial assessment and then your assigned clinician will meet with you from there on.
6. Every 3 months, you, your family, and your clinician will discuss your progress in a Treatment Plan Review, which you (and your parent, if under 18) will sign.
7. By the end of treatment, you should be feeling better and you should have met your goals for treatment. Your family (and teacher, if school services are provided) should also have learned some ways to help you to do your best.
8. At the final session, your clinician will make sure that you are prepared with any services that you will still need after treatment ends.

Your Rights:

1. **Respect:** You and your family will be treated with respect by all A Core Connection staff.
2. **Anti-Discrimination:** Your religious and cultural beliefs will be respected. You will not be treated differently based on your age, disability, race, sex, or ethnic group.
3. **Freedom of Choice:** You have the right to change providers, refuse referrals for other services, or stop services at any time, without penalty.
4. **Confidentiality/Privacy:** You have the right to decide when and with whom to share your private information. Information about you will not be shared with other people without your permission (or your parent's, if you are under 18). There are exceptions to this rule, including if we have to report suspected abuse, neglect, or exploitation, if we believe someone's life is in danger, or if a judge orders it. Information shared in an individual session with a child may have to be shared with a parent, but the clinician will only share information if it is necessary for treatment.
5. **Access to Records:** You have the right to read and have copies of your chart information in a timely manner. We might require that we be present to explain what is written, however, and there may be a cost for some records.
6. **Grievances:** If you make a complaint or file a grievance, your services will not be terminated or affected in any way.
7. **Freedom from Harm:** We are required by law to report any suspected abuse, neglect, or exploitation. If you need to report abuse, neglect, or exploitation, call the Abuse Hotline: 1-800-96-ABUSE (800-962-2873).

Your Responsibilities:

1. **Attendance:** You and your family will keep appointments made with the clinician. If you cannot keep an appointment, call your clinician ahead of time to reschedule.
2. **Participation:** You and your family will participate in treatment and will follow through with the strategies agreed upon during treatment sessions.
3. **Notification:** You will inform the clinician of any changes to your address or phone number
4. **Payment:** You are responsible for any services, co-payments or deductibles not paid by your insurance.

Agency Rights & Responsibilities:

1. All agency staff will behave in a professional manner, including being trustworthy, considerate, polite, and discrete.
2. We will provide consistent, high quality treatment to you and your family. The clinician should notify you if he/she is running late for a scheduled appointment. If a session has to be cancelled, the clinician will notify you in advance.
3. We will keep an accurate written record of the treatment we provide.
4. We have the right to terminate services if you fail to follow through on your responsibilities (listed above) or if we believe that maximum benefit has been reached. If your treatment is discontinued and you still need help, you will be given a referral to another agency that can help.

If you have any questions, you can contact the office at 407-789-2673.

If you are in crisis and your clinician is not available, you can call the crisis hotline: (407) 425-2624. In the event of an emergency (danger to self or others), call 911.

Complaints/Grievances: If you have a concern that cannot be resolved by speaking with the staff directly, please contact the Operations or Clinical Director. They will respond to your concern within 2 business days.

Health & Safety

This handout is to let you know some basic information about staying healthy. It also includes information about A Core Connection's health & safety policies and emergency procedures.

Physical & Emotional Wellness:

1. **Prevent disease.** Wash hands thoroughly with soap **BEFORE** eating, treating wounds, & putting in contacts, and **AFTER** using the bathroom, sneezing, & blowing your nose.
2. **Keep yourself & your home clean.** Shower daily & brush your teeth 2x daily. Don't leave trash, dirty dishes, and food out, as these attract bugs, which bring disease.
3. **Prevent unwanted pregnancies.** If you cannot afford or emotionally handle a child right now, get on reliable birth control. Remember it only takes once.
4. **Prevent sexually transmitted diseases (STD):** Most birth control methods do not prevent STDs, so use a condom if you are not 100% sure that your partner is STD-free.
5. **Sleep well at night:** Lack of continuous sleep decreases ability to focus & increases irritability/emotionality. Adults should get 8 hours, high school 8-9 hours, middle school 9-9½ hours, and elementary 10-11 hours.
6. **Eat a healthy diet.** Eat less fast food, snack food, and fried food. Eat more fruits and vegetables. Eat when you are hungry, not because you are bored or stressed.
7. **Exercise your body.** Spend less time sitting. Walk, jog, or bicycle several times per week. Do weight-bearing exercises to preserve bone strength.
8. **Exercise your brain.** Reduce TV and video game time. Read books, magazines or the newspaper. Play cards or board games that make you think. Work the puzzles in the newspaper. Do a jigsaw puzzle.
9. **Behave in positive ways.** Smile more. Compliment others. Socialize with happy people. Do things you enjoy. Talk about positive things more than negative. Remember that happiness is a choice.

A Core Connection's Health & Safety Policies:

1. **Abuse & neglect:** All staff are legally required to report allegations or suspicion of abuse or neglect of children (age 0-17), elderly, or disabled adults.
2. **Danger to self or others:** If a clinician determines that a client or family member is likely seriously harm him/herself or someone else, the clinician has a responsibility to protect that person and others from harm. In this case, more secure placement, such as hospitalization may be required on an emergency basis.
3. **Tobacco:** The use of tobacco products is not allowed in our office or office building. Use of tobacco is permitted in designated areas away from the building entrance or stairway. Our staff are not allowed to use tobacco products in the presence of clients or their families.
4. **Drugs/alcohol:** The use of recreational drugs or alcohol prior to or during sessions is not allowed. If a clinician determines that a client or other person present for the session is under the influence of alcohol or drugs, he/she may decide to cancel the session.
5. **Prescription medication:** If a legally prescribed medication taken prior to or during a session impairs the ability of a client or other session participant to benefit from treatment, the clinician may decide to cancel the session.
6. **Weapons:** Weapons of any kind are not permitted in an A Core Connection office. During in-home sessions, all firearms must be maintained in a securely locked area.
7. **Advance Directives:** If you have an advance directive, please let your clinician know. We will need a copy of this document for your file.

A Core Connections Emergency Procedures:

1. **Violent or threatening situations:** If a client or other person present for a session becomes violent or threatening, your clinician will try to verbally de-escalate him/her. If he/she is unsuccessful and the person continues to present a danger, 911 will be called. Our staff are not permitted to restrain clients or anyone else.
2. **Medical emergencies:** If a medical emergency occurs during a session, your clinician will call 911 and follow the instructions given.
3. **Natural disasters:** If you or your clinician are aware of an incoming natural disaster (e.g., hurricane, tornado, flood), check the National Weather Service and follow their instructions. If the weather service says that it is unsafe to drive, you may need to cancel and reschedule your session. If you are at our office, your clinician will stay at the office with you until it is safe to leave. For home visits, your clinician may need to remain at your home until the weather clears and it is safe to drive again.
4. **Power outage:** If the electricity in the office goes out for more than 15 minutes, your session will be cancelled and rescheduled.
5. **Fire extinguishers & first aid kits:** There is a fire extinguisher and a first aid kit in each office. Your clinician will know where they are located.

If you have any questions, you can contact the office at 407-789-2673

If you are in crisis and your clinician is not available, you can call the crisis hotline: (407) 425-2624. In the event of an emergency (danger to self or others), call 911.

Complaints/Grievances: If you have a concern that cannot be resolved by speaking with the staff directly, please contact the Operations or Clinical Director. They will respond to your concern within 2 business days.