Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

The House Next Door

Therapy Department

Client Intake Packet

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

THE HOUSE NEXT DOOR

Therapy Site: DeLand Today's Date: ____/____/_____

Print name of parent/guardian for minors:_____

Client Name: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

What sex were you assigned at birth, on your original birth certificate? : ☐ Male ☐ Female

Current gender identity. How do you describe yourself? (Choose One)

☐ Male ☐ Female ☐ Transgender ☐ Do not identify as male, female or transgender

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ BiRacial ☐ Other

Ethnicity: ☐ Hispanic or Latino

Ethnicity Detail: ☐ Puerto Rican ☐ Cuban ☐ Mexican ☐ South American ☐ Other Hispanic

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Street Address: _____

Do you wish to be on The House Next Door's mailing list? ☐ Yes ☐ No

Home Phone # (_____)_____-_____ Cell Phone #: (_____)_____-_____

OK to contact at home or leave a message? ☐ Yes ☐ No What hours?: _____

Monthly Income from Paid Employment: $_____ Monthly Income from other sources:

Social Security: $ _____ SSI: $ _____ TANF/Public assistance: $ _____ Food Stamps $ _____

# of people in the household: _____ List all individuals in your household:

First Name	Last Name	DOB	Sex	Relationship

Email:_____ Okay to send email? ☐ Yes ☐ No

Please list all medications you currently use:_____

_____

For clients 0-18, please list immunizations:_____

Is religion/ spirituality a source of support for you? ☐ Yes ☐ No

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My cultural identity is: ☐ Very Important ☐ Important ☐ Not Important

Do you have any preferences/ special concerns relating to your religious beliefs/ethnic identity that we need to consider in planning your services? _____

Please check the family structure that best describes your home:

☐ Biological Family ☐ Step-Parent Family ☐ Singe Parent Family ☐ Other (specify):_____
☐ Foster Care ☐ Relative Care Giver

Employer/School:_____ Occupation/Grade Level: _____

Work phone #: (____)_____-_____ OK to contact at work? ☐ Yes ☐ No
When?:_____
Person to be contacted in an emergency: _____ Phone #:_____
Have you, or any member of your immediate family: 1) ever been in a House Next Door program before? ____
2) ever been in counseling? _____
If yes, type of program and where? _____
Who referred you to The House Next Door? _____

I CERTIFY THAT ALL INFORMATION GIVEN ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

☐ By checking this box I consent to this document electronically

_____ _____

Parent Signature Date

_____ _____

Client Signature Date

Fee Information- Office Use Only

☐ WVHA 1505 ☐ AMH 1504 ☐ Teen Court 1500 ☐ Self@_____ 01 ☐ Other:_____
☐ Medicaid ☐ Medicaid HMO:_____ Enrollment #: __ __ __ __ __ __ __ __ __ __
Name of HMO

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Client Rights & Responsibilities

The House Next Door is committed to providing service to you [the client] without regard to race, sex, color, religion, handicapping condition, national origin, or ability to pay in a manner appropriate to your need.

AS A CLIENT OF OUR AGENCY, YOU HAVE THE RIGHT TO:

INDIVIDUAL DIGNITY, to be treated in a respectful and confidential manner.

NONDISCRIMINATORY SERVICES, to be provided services without regard to race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, or prior service departures against medical advice; to be afforded the opportunity to participate in the formulation and periodic review of your individualized service plan.

QUALITY SERVICES, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

WITHDRAW YOUR CONSENT for any specific activity with no penalty from the agency.

CONFIDENTIALITY OF CLIENT RECORDS, The House Next Door has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality which are listed below:

- If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of the threatened person(s). If abuse or neglect of a child, elder or disabled person is known or suspected, we are required to report it to the Florida Abuse Hotline.
- If our agency receives a court order for client records, staff deposition or court testimony, we are required to comply. We are also required to report attendance compliance by court ordered clients.
- In the course of review of records on agency premises by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payor providing financial assistance or reimbursement to the service provider; however, reports produced as a result of such audit or evaluation may not disclose client names or other identifying information and must be in accord with federal confidentiality regulations.

In the event that group services are provided, it is acknowledged that HND or its staff cannot be held responsible for a breech of confidentiality on the part of a peer group member.

EXPRESS DISSATISFACTION with agency services directly to the Operations Director or to the Executive Director. Forms are available at the front desk at every site to submit a written concern or both the Operations Director and the Executive Director can be reached at 734-7571, Monday – Friday.

AS A CLIENT OF OUR AGENCY, YOUR RESPONSIBILITIES INCLUDE:

Appointments: Regular attendance is very important to ensure progress with the concerns and issues that have been presented. If there is an emergency and you need to cancel or reschedule an appointment, please call the office as soon as you know of this change to reschedule. **Participation**: Your honest and accurate reporting of dilemmas and concerns is vital to your progress. To the best of your ability, you must be open and honest in your sessions and strive to follow the recommendations in your service plan. **Safety**: It is important that you and your children exercise appropriate caution, control and safe behavior on the premises. **Termination**: Services may be discontinued for repeatedly missed appointments; if you come to appointments intoxicated and/or under the influence of substances; or if you show evidence of inappropriate behavior. You [the client] are asked to sign below to verify that you have been made aware of your rights and responsibilities and the policies on confidentiality and have received a copy of both the agency's Notice of Privacy Practices and these rights and responsibilities.

☐ By checking this box I acknowledge that I am consenting to Rights and Responsibilities electronically

_____ _____

Client and Parent Signature Date

_____ _____

Staff Signature Date

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

Client Rights & Responsibilities

The House Next Door is committed to providing service to you [the client] without regard to race, sex, color, religion, handicapping condition, national origin, or ability to pay in a manner appropriate to your need.

AS A CLIENT OF OUR AGENCY, YOU HAVE THE RIGHT TO:

INDIVIDUAL DIGNITY, to be treated in a respectful and confidential manner.

NONDISCRIMINATORY SERVICES, to be provided services without regard to race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, or prior service departures against medical advice; to be afforded the opportunity to participate in the formulation and periodic review of your individualized service plan.

QUALITY SERVICES, suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

WITHDRAW YOUR CONSENT for any specific activity with no penalty from the agency.

CONFIDENTIALITY OF CLIENT RECORDS, The House Next Door has the obligation to obtain your written consent prior to any exchange of confidential information. There are a few exceptions to confidentiality which are listed below:

- If you present a danger to yourself or others, we are legally, ethically and morally required to protect the safety of the threatened person(s). If abuse or neglect of a child, elder or disabled person is known or suspected, we are required to report it to the Florida Abuse Hotline.
- If our agency receives a court order for client records, staff deposition or court testimony, we are required to comply. We are also required to report attendance compliance by court ordered clients.
- In the course of review of records on agency premises by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payor providing financial assistance or reimbursement to the service provider; however, reports produced as a result of such audit or evaluation may not disclose client names or other identifying information and must be in accord with federal confidentiality regulations.

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_____ _____

Client Signature Date

_____ _____

Parent Signature Date

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THE HOUSE NEXT DOOR THERAPY INFORMED CONSENT

Please read and sign to indicate that you understand the policies and procedures of our Therapy Department.

1. **Services:** We provide many different types of therapy for all ages for families with teens, specialized group therapy, individual, family, and play therapy. Therapy can vary in length depending on the collaborative efforts between therapist and client. The goals for counseling are developed with the therapist, are based on the client's needs and concerns, and are reviewed on a regular basis to monitor progress. Our counseling services are voluntary. If the client has court documentation for counseling, a copy of this documentation must be provided prior to your next counseling session. Social Security numbers of family members receiving services are required for identification purposes and funding requirements. *When bringing children for counseling services or if there are children waiting in the waiting area, the adult providing transportation is required to stay on the premises during the session.*
2. **Appointments:** Regular attendance to therapy is very important to ensure progress with the concerns and issues that have been presented. Please make every effort to keep appointments and be on time. Therapy sessions are typically fifty minutes in length. If there is an emergency and you need to cancel or reschedule an appointment, please call the office as soon as you know of this change to reschedule with your therapist.
3. **Staff:** Therapists providing counseling are Licensed and Registered Clinical Social Workers, Marriage and Family Therapists, Mental Health Counselors, or they are Master Degree Interns in these fields supervised by Licensed Therapists.
4. **Fees:** Therapy session fees are based on the client's income and ability to pay. The fee structure is developed on a sliding scale. All fees are due at the beginning of each session. Some programs are covered by a grant and there is no cost to the clients.
5. **Live Supervision:** The House Next Door is a teaching facility, providing direct supervision to interns and students credentialed and cleared for the provision of therapy services. This involves live supervision/recording in which the session is observed directly by the supervisor or other interns. This process is for training, and clients do this on a voluntary basis. HIPAA guidelines are followed.
6. **Termination:** The client is expected to inform the therapist if the client plans to discontinue counseling for any reason. The final session is an important part of the therapeutic process and helps to summarize the progress and appreciate the change and growth that has occurred. If a client does not show up for two of their appointments without calling to cancel or reschedule, the case file will be closed and a note to the client is sent out. The therapist may discontinue therapy if the client is currently involved in domestic violence with a partner, acute intoxication or impairment, or has shown violent or threatening behavior. The client may be given a referral to other, more appropriate services, for issues of substance abuse requiring more intensive intervention, violence, or sever mental health issues.
7. **Benefits/Risks:** The majority of individuals and families that obtain counseling benefit from the process. Self-exploration, gaining insight, exploring options for dealing with problem behaviors, learning new skills, or venting difficult feelings/experiences are generally quite useful, but some risks do exist. As counseling is begun, please understand that some experience unwanted feelings and that examining old issues may produce unhappiness, anger, guilt, or frustration. These feelings are difficult, but a natural part of the psychotherapeutic process and often provide the basis for change. Important personal decisions are often an outcome of counseling. These decisions, including changing behavior, exploring employment options, substance use patterns, schooling and relationships, are likely to produce new opportunities as well as unique challenges. Sometimes a decision that is positive for one family member will be viewed quite negatively by another. Don't be hesitant to discuss counseling goals, procedure, or your impressions of the services being provided. If ever you don't understand a suggestion or comment that has been made, please ask for clarification.

*****I have read and understand the nature and limits of the therapy services provided by The House Next Door and I agree to participate. I have received House Next Door Privacy Practices-Protective Heath Information.*** _____(initials)**

☐ By checking this box I acknowledge that I am consenting to Informed Consent electronically

_____ _____

Client(s) Signature(s) **Date**

_____ _____

Therapist's Signature **Date**

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THE HOUSE NEXT DOOR THERAPY INFORMED CONSENT

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14. **Benefits/Risks:** The majority of individuals and families that obtain counseling benefit from the process. Self-exploration, gaining insight, exploring options for dealing with problem behaviors, learning new skills, or venting difficult feelings/experiences are generally quite useful, but some risks do exist. As counseling is begun, please understand that some experience unwanted feelings and that examining old issues may produce unhappiness, anger, guilt, or frustration. These feelings are difficult, but a natural part of the psychotherapeutic process and often provide the basis for change. Important personal decisions are often an outcome of counseling. These decisions, including changing behavior, exploring employment options, substance use patterns, schooling and relationships, are likely to produce new opportunities as well as unique challenges. Sometimes a decision that is positive for one family member will be viewed quite negatively by another. Don't be hesitant to discuss counseling goals, procedure, or your impressions of the services being provided. If ever you don't understand a suggestion or comment that has been made, please ask for clarification.

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_____ _____

Client(s) Signature(s) **Date**

_____ _____

Therapist Signature **Date**

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The House Next Door Informed Consent for Children in Services
Only applicable for non-offending caregivers

It is important to us that you understand our legal responsibilities in providing service to your child(ren). Florida Statutes mandates that non-custodial parents have equal rights and obligations as custodial parents, unless that authority is restricted by the Courts. If this is applicable in your case, please provide the Court Order that restricts parental privileges.

In the absence of a Court Order, the agency is required to allow both parents to:

- Participate in sessions at the clinical judgment of the therapist
- Have input in developing the goals of the treatment plan
- Have access to the child's records
- Pick up the child from our facility

If both parents do not live in the same house with the child, please be aware that we will attempt to inform the child's other parent that your child is entering services with us.

We appreciate your understanding and cooperation in abiding by these legal requirements.

Name of absent parent: _____
Current mailing address: _____
_____
_____

☐ N/A- both parents live within the same household

I CERTIFY THAT ALL INFORMATION GIVEN ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

☐ By checking this box I acknowledge that I am consenting to this document electronically

Parent signature: _____ **Date: _____**

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AUTHORIZATION TO FILE INSURANCE CLAIMS

I, _____, authorize The House Next Door to file claims to my insurance company which I have listed below for services rendered. I understand that I am financially responsible for any deductible, co-insurance, co-pay or claim denial that my insurance company deems as my responsibility.

☐ By checking this box I acknowledge that I am consenting to this document electronically

_____ _____

Signature of Client Date

Insurance Company Information: _____

Policy Holder or Subscriber Name:_____

Policy Number:_____

Client's Relationship to Policy Holder:

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☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other_____

THE HOUSE NEXT DOOR, INC.
AUTHORIZATION TO DISCLOSE AND/OR RELEASE INFORMATION
FOR PRIMARY CARE PHYSICIAN (PCP)

☐ Deland	☐ Deltona	☐ Daytona Beach
114 S. Alabama Ave.	840K Deltona Blvd	1000 Big Tree Road.
Deland, Florida 32720	Deltona, Florida 32725	Daytona, Fl. 32119
(386)-738-9169	(386)-860-1776	(386)- 301-4073

I, _____, do hereby
Name of Client/Legal Guardian
authorize the House Next Door, Inc. to disclose information to and/or obtain information

from _____which will include the following:
Name of Primary Care Physician

☐ Admission/Discharge ☐ Progress Notes ☐ Other: _____
☐ Treatment Plan ☐ Summary
☐ Medication Records ☐ Diagnosis _____
☐ Physician Evaluation ☐ Psychiatric Evaluation

Regarding: _____
Client Name **D.O.B.** **Social Security #**

I understand that this information will be used solely to assist in providing appropriate services and will be held in strict confidence. I also understand that in specific circumstances, where required by law and as defined by the agency's Notice of Privacy Practices, my protected information may be subject to re-disclosure.

I understand that I may revoke this Authorization at any time by providing written notice to The House Next Door, as listed above, except to the extent that action has been taken in reliance thereon. I further understand that my refusal to authorize release of records or revoking authorization will not prevent me from receiving services at The House Next Door.

I understand that I have the right to review information disclosed by this release.

If no proper notice of revocation is received, this consent will expire automatically 180 days after the date indicated hereon. A photostatic copy or fax of this document shall be valid and effective as the original.

☐ **Yes.** I consent to the release of information as indicated above to my PCP.
☐ **No.** I do not consent to release information to my PCP.

☐ By checking this box I acknowledge that I am consenting to this document electronically

_____ _____
Client/Parent Signature **Date**

_____ _____
Therapist Signature **Date**

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

THE HOUSE NEXT DOOR, INC.
AUTHORIZATION TO DISCLOSE AND/OR RELEASE INFORMATION

☐ Deland	☐ Deltona	☐ Daytona Beach
114 S. Alabama Ave	840K Deltona Blvd	1000 Big Tree Road.
Deland, Florida 32720	Deltona, Florida 32725	Daytona, Fl. 32119
(386)-738-9169	(386)-860-1776	(386)- 301-4073

I, _____, do hereby
Name of Client/Legal Guardian
authorize _____ of The House Next Door, Inc. to disclose information to and/or obtain from _____which will include the following:

RE: _____
Client Name **DOB** **Social Security #**

- ☐ Admission/Discharge
- ☐ Treatment Plan
- ☐ Medication Records
- ☐ Progress Notes
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Medication Records
- ☐ Team Conference Reports
- ☐ Diagnosis, Prognosis
- ☐ Summary
- ☐ Other: _____ _____ _____

I understand that this information will be used solely to assist in providing appropriate services and will be held in strict confidence. I also understand that in specific circumstances, where required by law and as defined by the agency's Notice of Privacy Practices, my protected information may be subject to re-disclosure.

I understand that I may revoke this Authorization at any time by providing written notice to The House Next Door, as listed above, except to the extent that action has been taken in reliance thereon. I further understand that my refusal to authorize release of records or revoking authorization will not prevent me from receiving services at The House Next Door. I understand that I have the right to review information disclosed by this release. If no proper notice of revocation is received, this consent will expire automatically **180** days after the date indicated hereon. A photostatic copy or fax of this document shall be valid and effective as the original.

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_____ _____
Client Signature **Date**

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Witness Signature **Date**

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THE HOUSE NEXT DOOR
Fee Agreement/Funding Proof Information

Copies Made and Attached to File:

Identification-*check two* (2 proofs required for certain fund sources; one must be photo ID)

- ☐ Birth Certificate
- ☐ Florida ID card
- ☐ Social Security Card
- ☐ Any Gov't. issued ID card
- ☐ Florida Driver's License with correct address
- ☐ Farmworker Assn. of Florida, Inc., Photo ID
- ☐ Alien Registration (Green Card) Form I-151 or I-551
- ☐ Official Document: shows name, address, and SS#

Residency-*check two*

- ☐ Property Tax Bill
- ☐ Utility Bill (past 3 months)
- ☐ Vehicle Registration
- ☐ Official Mail at the address
- ☐ Lease, rent/mortgage agreements (within past 3 months)
- ☐ WVHA Client Registration Form
- ☐ WVHA Verification of Support Form
- ☐ Proof of children registered in area schools

Family Income: _____ Number in Family: _____

Income Verification- *Check One*:

- ☐ Most recent Tax return, 1040, and W-2s for all wage earners in the household
- ☐ Pay stubs for previous 8 weeks or Income Verification from employer
- ☐ Bank Statements (previous 8 weeks)
- ☐ Medicaid Denial or Application letter
- ☐ Unemployment Statement
- ☐ Veteran's Benefits
- ☐ Financial Settlements
- ☐ Child Support/Alimony
- ☐ Pensions/Retirement/Interest
- ☐ Worker's Comp statement
- ☐ Social Security Benefits for any family member
- ☐ Unemployment Verification Form

Based on the House Next Door Minimum Fee scale:

Fee For Initial Assessment: _____ Fee For therapy sessions: _____

Other Arrangements as approved by clinic director/supervisor:_____

_____

Medicaid/HMO Information:

8 digit Gold Card #: _____

Name of HMO: _____

10 digit ID#: _____

Authorization #: _____ Co-Pay Amount: _____

I agree to pay the above fee or Co-Pay at the time of services rendered. I understand that it is my responsibility to maintain Medicaid eligibility. If Medicaid eligibility is not confirmed initially or verified each month (HND staff does the eligibility checks), I will be responsible for the regular fee based on family income.

☐ By checking this box I acknowledge that I am consenting to this document electronically

Client Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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West Volusia Hospital Authority (WVHA) Eligibility Worksheet

(for clients requesting assistance with funding for services)

Proof of Residency (2 required), with same address (copies needed in chart):

Examples Include:

- ☐ Property Tax Bill
- ☐ Utility Bill (past 3 months)
- ☐ Vehicle Registration
- ☐ Official Mail at the address
- ☐ Lease, rent/mortgage agreements (within past 3 months)
- ☐ WVHA Client Registration Form
- ☐ WVHA Verification of Support Form
- ☐ Proof of children registered in area schools

Identification (2 required, one must be photo ID; copies needed in chart):

Examples Include:

- ☐ Birth Certificate
- ☐ Florida ID card
- ☐ Social Security Card
- ☐ Any Gov't. issued ID card
- ☐ Florida Driver's License with correct address
- ☐ Farmworker Assn. of Florida, Inc., Photo ID
- ☐ Alien Registration (Green Card) Form I-151 or I-551
- ☐ Official Document: shows name, address, and SS#

Income (Copy needed in chart)

Examples Include:

- ☐ Most recent Tax return, 1040, and W-2s for all wage earners in the household
- ☐ Pay stubs for previous 8 weeks or Income Verification from employer
- ☐ Bank Statements (previous 8 weeks)
- ☐ Medicaid Denial or Application letter
- ☐ Unemployment Statement
- ☐ Veteran's Benefits
- ☐ Financial Settlements
- ☐ Child Support/Alimony
- ☐ Pensions/Retirement/Interest
- ☐ Worker's Comp statement
- ☐ Social Security Benefits for any family member
- ☐ Unemployment Verification Form

Other Income/Financial Assets (To be reported below by client requesting assistance)

Yes	N/A	
-	-	**From Self Employment:**
☐	☐	Bank Statements for all business/self employment accounts
☐	☐	Previous Year's Business Tax Return (within 3 months)
☐	☐	Current Business Financial Statements
-	-	**Assets:**
☐	☐	Checking and Savings Accounts
☐	☐	Equity value of real property other than homestead
☐	☐	Cash surrender value of Life Insurance (if combined value exceeds $1500)
☐	☐	Additional automobiles, motorized vehicles, motorcycles, RVs

Comments:

☐ By checking this box I acknowledge that I am consenting to this document electronically

_____ _____

Client Signature verifying information listed above — Date

_____ _____

Staff Signature verifying above proofs are copied and collected — Date

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TO HOUSE NEXT DOOR THERAPY CLIENTS

Your future appointments will be decided at the time of your Intake visit at The House Next Door. If you are unable to keep your appointment, we would appreciate it if you would call our office (try to give 24 hour notice) to cancel and/or reschedule your appointment.

Deland: (386) 738-9169 Daytona: (386) 301-4073

Deltona: (386) 860-1776 Flagler: (386) 301-4073

Regarding "no shows" (failed appointments): It is our policy that cases will be closed when clients miss two consecutive appointments without calling or canceling these appointments. In these situations, we are obliged to assume that you no longer wish to receive services, and will automatically discharge you from the system. You are always welcome to call back at any time thereafter, and have your name added to our referral list for a future appointment time.

Regarding inactivity on counseling cases: As there are many members of our community who are waiting for services, we cannot leave cases open indefinitely if services are not being delivered. It is our policy that we will automatically close cases in which there has been no activity over a 30 day period. There are, at times, instances in which attendance is not possible (for example, an extended illness). If you need special arrangements, please contact your therapist so that the case will not be automatically closed. We appreciate your cooperation regarding our cancellation and "no show" policy. If you have questions, feel free to speak with your therapist, the Site Supervisor, or the Administrative Assistant.

☐ By checking this box I acknowledge that I am consenting to this document electronically

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

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Nurturing Families
Building Communities

The House Next Door

The House Next Door supervises graduate level and registered interns. All student interns are completing an approved graduate curriculum in the healing arts, either mental health counseling, social work or marriage and family therapy, and have had prior experience in their field of practice. Throughout their internship, a licensed mental health professional – mental health counselor, social worker, or marriage and family therapist closely supervise student interns. All registered interns have completed their course work for graduate school, have earned a master's degree in their field and are closely supervised by a Qualified Clinical Supervisor.

The intern is: ☐ graduate level student : Name: _____

☐ registered intern pursuing licensure: Name: _____

The supervisor is: ☐ Ann Grell, LMHC, 386-738-9169

☐ Morgan Perun, LMHC, 386-738-9169 ☐ Stefanie Yockey, LMHC, 386-301-4073

Supervision may include audio or videotaping and/or direct or indirect observation. Additionally, there may be times when student interns will have to present a case to their graduate class in partial fulfillment of their graduation requirement. Registered interns may also have to present cases to their supervisor in partial fulfillment of their supervision requirements. I confirm that I understand and agree to the above arrangement.

☐ By checking this box I acknowledge that I am consenting to this document electronically

Signature _____Date _____

Witness_____Date_____

Confidentiality Notice: Federal & State regulations require that all information contained in this document be treated as CONFIDENTIAL

The House Next Door S.A.T.P.
Victim's Compensation Agreement

If you are accessing benefits through the Victim's Compensation Program, you must provide a copy of your letter of eligibility status so we can continue to provide services to you at no cost.

You should receive this letter by mail from the *Florida Office of the Attorney General* no later than 2 weeks after your first appointment.

If you do not receive a letter by that time, you should contact the Office of the Attorney General (1-800-226-6667) to request the status of your claim.

If you are determined ineligible, that does not indicate our refusal to provide services. You can make arrangements with our Scheduling Coordinator (386) 860-1776 to continue counseling on another grant program or a sliding scale fee as applicable.

I acknowledge this agreement and will bring the letter from the Office of the Attorney General, once received, to the next counseling session.

☐ By checking this box I acknowledge that I am consenting to document electronically

_____ _____

Client/Client's Guardian Date

_____

Therapist

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Victim's Compensation Instructions
S.A.T.P. Program

According to Florida statues, victims of a crime are entitled to receive compensation benefits for mental health counseling if they meet eligibility requirements. In order to ensure that benefits are approved and you are not billed for counseling services at our agency, there are a few procedures to follow.

1. Complete a Victim's Compensation Claim Form. Our front desk will give you this form and your therapist can assist you if needed.

2. Our agency will fax the claim form to the Office of the Attorney General.

3. You will receive a letter from the *Florida Office of the Attorney General* notifying you of the status of your claim within 2 weeks after your first appointment. Provide a copy of that letter to your therapist during your next scheduled visit.

4. If the letter states you must furnish additional information, our Administrative Assistant can help with this process (860-1776).

5. The Office of the Attorney General does NOT release eligibility information directly to us so this could delay scheduling and requires your cooperation.

6. If you are ineligible for compensation, our Administrative Assistant will set up another payment arrangement based upon grant availability or a sliding scale fee.

7. If we do not have a final letter of determination within 30 days after your first session, we will automatically arrange another payment option.

8. You can contact the Attorney General to request the status of your claim at any time during the process (1-800-226-6667).

9. Finally, in some cases, we may not reschedule you until a response is received.

At any time throughout the process, please feel free to ask your therapist for assistance, or contact our program staff:

Administrative Assistant 386-860-1776