# CHILD/ADOLESCENT INFORMATION FORM

Date: _______________

Name: _______________________________________________

Address______________________________________________

City__________________ State___________ Zip_____________

DOB: _________ Home Phone___________________ SS#_____________________________

Hobbies: ______________________________________________________________________

School: _________________________________ Grade: ____________________

Parent/s Name: Mother______________________________ DOB: __________

SS#______________________ Cell Phone # ______________________________

Father ______________________________________________ DOB: ______________

SS#______________________ Cell Phone # ______________________________

Who is the Primary Insurance Subscriber? __________________________________________

Mother's Employer: ______________________ Contact at work? Yes, No Phone____________

Father's Employer: _______________________ Contact at work? Yes, No Phone____________

Other children in your home:

Name: _________________ DOB: ________ Name: ____________________DOB__________

Name: ______________ __ DOB: ________ Name: ____________________ DOB: _________

Medications, dosages if any: _______________________________________________________

Please explain why you are seeking counseling at this time:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

# INSURANCE CONSENT

I understand that I am personally responsible for the cost of services not covered by my insurance including but not limited to unmet deductibles, co-payments and any fees or portions of fees not paid by my insurance carrier. I understand that these fees are due at the time of service.

I understand that I am personally responsible to provide Joel S. Brooks, LCSW of any changes in my insurance coverage. I will be responsible for any fees not paid by my insurance due to changes not being provided in a timely manner.

I hereby choose to have my insurance company billed for these services. Benefits due to me under the above policy are hereby assigned to Joel S. Brooks, LCSW. I understand that my insurance company will require specific diagnostic and treatment information. I consent to the release of all requested confidential information to Mr. Brooks' billing agent, D. Black Practice Services and my insurance company for the purpose of processing my claim. I understand that Joel S. Brooks, LCSW cannot be responsible for confidential information once it is released to my insurance.

Client Printed Name: _______________________________ Date: ___________________
(Parent or guardian)

Client Signature: ___________________________________

**RIGHTS AND EXCEPTIONS TO THE RELEASE OF CONFIDENTIAL INFORMATION**

Joel S. Brooks, LCSW, maintains a strict ethical and legal obligation to protect the privacy of clients by not disclosing names, diagnosis or any other personal information disclosed in the course of treatment to anyone outside of the treatment setting. Treatment information will only be released to appropriate persons or institutions, (such as physicians, mental health professionals, etc.) upon a signed consent to do so.

All inquires about any client of Mr. Brooks, whether by mail, telephone or person will be responded to with a statement such as, “I cannot release that information unless I have the patient’s written consent.”

It is very important to know and understand that there are rare occasions when Mr. Brooks will be required by law to breach confidentiality. The exceptions to confidentiality are as follows:

1) Cases that involve suspicion or knowledge of abuse or neglect of children, elderly persons or disabled adults. Florida law requires all Mental Health Professionals and a variety of other professionals to immediately report any suspected or known abuse, neglect or abandonment of a child, elderly person or disabled adult. These reports will be made to the Florida Abuse Registry.

2.) When there is a clear and immediate probability of physical harm to self or to other individuals or to society and the therapist communicates the information only to the potential victim, appropriate family members or law enforcement or other appropriate officials.

3) When the therapist is a defendant in a legal proceeding arising from a complaint filed by the client.

4) A court order is obtained for an evaluation or report and the therapist is appointed or retained to provide these services. However, only the records required to prove the case should be released.

I have read and understand the terms as stated above. I also understand that Mr. Brooks can not be held accountable for any breach of confidentiality as long as the release of information falls within the exceptions as described.

__________________________________ _____________________

Client Signature Date

# NOTICE OF PRIVACY PRACTICES Joel S. Brooks, LCSW

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

**PURPOSE OF THIS NOTICE**

Joel Brooks, LCSW is required by law to maintain the privacy of your confidential health care information, known as Protected Health Information, (PHI) and to provide you with this notice of legal duties and privacy practices with respect to your PHI. This notice describes your legal rights, advises you of privacy practices and lets you know how Joel Brooks, LCSW is permitted to use and disclose PHI about you.

This notice is covered under HIPAA (Health Insurance Portability & Accountability Act) Any state law that is more stringent than the HIPAA rules and regulations have priority.

**HOW YOUR PROTECTED MENTAL HEALTH INFORMATION MAY BE USED AND DISCLOSED**

Uses and Disclosures Requiring Your **Consent**:

**For treatment:** A referral to other mental health practitioners who are involved in providing your mental health care, for assessment and or long term treatment would require a signed consent from you to release and or receive PHI about you to appropriately coordinate your care. This also applies to any other persons or organizations that do not have your written consent or authorization to receive you PHI.
For uses and disclosures beyond treatment and operations purposes, your written authorization, (sign permission) is required.

Uses and Disclosures **Not Requiring Consent or Authorization**:

**For mental health care operations:** Your PHI may be used/disclosed to "Business Associates" who use your PHI for only the purposes they are intended. These Business Associates include billing services and your insurance carrier for the purposes of billing, continuity of care and certain insurance requirements that are necessary for your mental health treatment.

**The law provides that your PHI may be used/disclosed without your consent or authorization in the following circumstances**:

Suspected or known physical, sexual abuse or neglect.
Domestic violence in the presence of children
In response to a court order
To overt threat to health or safety, in order to avoid serious harm to self or others; *for example, a plan to commit suicide or a homicidal act.*

**For specific government functions:** Your PHI may be disclosed to military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment and for national security reasons, such as protection of the President.

**Uses and Disclosures Requiring You to Have an Opportunity to Object:** In the following situations your PHI may be disclosed if you are informed of the disclosure in advance and you do not object. However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest.

**To families, friends or others involved in your care.** Your PHP may be shared with these people who are directly related and involved in your care. These people may be notified about your location or general condition.

*For example, parents of a minor have certain rights to PHI. Also, family members may be located to inform them of the location of a client who was hospitalized after being diagnosed as severely depressed.*

**YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.** You have the following rights relating to your protected mental health information.

**To request restrictions on uses/disclosures:** You have the right to request limits on how your PHI will be disclosed. Your request will be considered within the limits of the law. To the extent that your restrictions are agreed upon, they will be provided in writing and will be abide by with the exception of emergency situations.

**To choose how you are contacted:** You have the right to ask that you are sent information at an alternative address or by an alternative means as long as it is reasonably easy to do. You may change your request at anytime.

**To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your protected health information if you put your request in writing. A response will be given as immediately as possible or within 30 days. If for some reason your request is denied, you will be given written reasons for the denial and given rights to have your denial reviewed.
If you want copies of your PHI, a charge for copying and preparation time may be imposed, but could be waived depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying and preparation.

**To request amendment of your PHI:** If you believe that there is a mistake or missing information in your treatment record of your PHI, you may request in writing that we correct or add to the record. You will receive a response as immediately as possible, or within 60 days. Your request may be denied if it is determined that the PHI is (I) amended and complete; (ii) not created by Joel Brooks, LCSW and or not a part of your record; or (iii) not permitted to be disclosed. Any denial will state the reasons for the denial. You will be informed as well as others about the amendments.

**To find out what disclosures have been made**: You have the right to receive an accounting (which means a detailed listing) of disclosures that have been made.

**HOW TO COMPLAIN ABOUT PRIVACY PRACTICES**

If you believe your privacy rights have been violated or if you are dissatisfied with these policies or procedures, you may file a complaint either with Joel Brooks, LCSW or with the federal government. Joel Brooks, LCSW will not take any action against you or change the treatment of you in anyway if you file a complaint. You may file a written complaint with the Office of Civil Rights (OCR), U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, and 61 Forsyth Street SW, Atlanta GA 30303-8909.

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided information on the standards for privacy of individually identifiable health information.

I recognize I may request a copy of these Privacy Practices in their entirety at any time.

Signature: __________________________________ Date: _______________________

Print Name: ________________________________

If you are signing as the client's representative:

Print your name: _____________________________

Describe your relationship to the client: ______________