1428 Sunrise Plaza Dr. Suites 2-3
Clermont, FL 34714
playpalstx@gmail.com

Intake Consent

Client Name: _____ Date of Birth: _____

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 mental health assessment and treatment through PLAY PALS THERAPY at the following locations:
YES NO Client Home: _____.

YES NO Client 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.

School: _____ teacher; _____ principal; _____ staff; _____guidance counselor
Family: _____ siblings; _____ grandparents; _____ foster parents; _____step-parents

Referral Agency: _____

Other Providers: _____
PRIVACY NOTICE: I have received a copy of the **PLAY PALS THERAPY** brochure. All your information will be kept confidential from unauthorized personnel.

PRIVACY EXCEPTIONS: There are some situations or circumstances that are required to report confidential information about your child and family. Is the law to report any abuse or suspicious neglect of a minor, disabled or elderly person. The provider has the legal obligation to report any concern to the Department of Children and Families 1-800-962-2873. If during services, the counselor receives information that someone's life is in danger it is his/her legal duty to warn the threaten individual. If a counselor or **PLAY PALS THERAPY** documents are subpoenaed by Court Order, it is our responsibility to provide records or appear in court to answer questions about our client.

FUNDING AUTHORIZATION: I authorize _____ (funding agency or resource) to pay for services directly to **PLAY PALS THERAPY**. 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 to process any claim and obtain reimbursement. I understand that I might refuse to sign this Authorization, but this action might not affect the ability to obtain treatment from **PLAY PALS THERAPY**.

GRIVANCE PROCEDURE: If you or family are not satisfying or agree with services or need to file a complaint or grievance please call the Program Director, Ramón Morales, 352-301-7535.

This page has been explained to me and family. I understand that I can terminate services at any time, however, I cannot revoke consent for action that has already been taken. A copy of this release shall be valid as the original for a period of one year from the date of signing.

THIS CONSENT EXPIRES AT THE TERMINATION OF TREATMENT OR 1 YEAR FROM THE DATE SIGNED
_____ (Initials) I received a copy of the "Notice of Privacy Practices" Please review it carefully.
_____ (Initials) I received a copy of the Client Manual, which identifies right and responsibilities including who to contact for grievance and complaints.

_____ _____ _____ _____
Parent/ Legal Guardian/Client Signature Date Primary Clinician Date

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Primary Care Physician Notification

Client Name: _____ Date of Birth: _____

This client's Primary Care Physician is as follows:

PCP Dr. Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone/Fax: _____

Email address: _____

I certify I do not have a PCP at this moment.

FOR NOTIFICATION PURPOSES ONLY -- DO NOT SEND RECORDS

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

Intake date: _____

Clinician Name: Heidy Aponte

Clinician phone: 352-301-7535

Acknowledgement:

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

1428 Sunrise Plaza Dr. Suites 2-3 – Clermont, FL 34714 Email: playpalstx@gmail.com
Fax 352-275-5024

- 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 Play Pals Therapy.
- 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/Legal Guardian Signature Date

1428 Sunrise Plaza Dr. Suites 2-3
Clermont, FL 34714
Ph: 352-301-7535 / Fax: 352-275-5024
playpalstx@gmail.com

Release of Confidential Information to Other Organization

I,		hereby authorize:
	(Print name of client or parent/guardian if minor child)	
PLAY PALS THERAPY, LLC - EMPLOYEE		
		PLAY PALS THERAPY, LLC

To release confidential information consisting of *(indicate the specific information that may be released, i.e., Psychiatric, Drug / Alcohol Records or Information, Medical Records or Information; Social History; Psychological Records or Information, Educational or School Records, etc…)* ***LIST SPECIFICALLY WHAT YOU WANT RELEASED:***

Regarding:		**My self**		**Minor Child**			
(check one)		**Child's Name:**				**Date of Birth:**	

For the purpose of assisting with diagnosis, treatment or rehabilitation to:

Enter name & Address of Organization to whom the information is being released:	

I understand that only the above-specified information can be disclosed by the above-specified organization.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987]

This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature which is ***enter date*** _____ or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken.

(Signature of Client or Parent/Guardian, if minor) ***(Date)***

(Signature of Witness) ***(Date)***

If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer: _____

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Clermont, FL 34714
Ph: 352-301-7535 / Fax: 352-275-5024
playpalstx@gmail.com

Release of Confidential Information

I,		hereby authorize:
	(Print name of client or parent/guardian if minor child)	

Name of Organization:	
Address of Organization:	

To release confidential information consisting of *(indicate the specific information that may be released, i.e. Psychiatric, Drug / Alcohol Records or Information, Medical Records or Information; Social History; Psychological Records or Information, Educational or School Records, etc…)* ***LIST SPECIFICALLY WHAT YOU WANT RELEASED:***

Medication and Dosages	**X**
Medical Conditions	**X**
Significant Events	**X**
Mental Health Concerns	**X**
Other:	**MENTAL HEALTH DIAGNOSE**

Regarding:		**Myself**		**Minor Child**			
(check one)		**Child's Name:**				**Date of Birth:**	

SEND FAX TO: 352-275-5024 / PLAY PALS THERAPY

Address:	***SUNRISE PLAZA DRIVE SUITES 2-3 / CLERMONT, FL 34714***
Attention:	RAMON MORALES

I understand that only the above-specified information can be disclosed by the above-specified organization.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987]

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(Signature of Client or Parent/Guardian, if minor) ***(Date)***

(Signature of Witness) ***(Date)***

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