



Information Acknowledgement

Client's Name _____

I have received the following informational materials from Family and Children's Services to review and utilize as needed:

- Privacy Notice
Client Rights & Responsibilities
Client Grievance Procedure
Information Sheet with Crisis Telephone Numbers
Information, such as a brochure, about agency services
Fee Schedule (where applicable)
What is Psychotherapy? or Case Management Services
Guidelines for Advance Directives for Mental Health Care
Consent for Services Form
Authorization of Release of Healthcare Information
Acknowledgement and Consent to use Electronic Communication

I have an Advance Directive for Mental Health Care. Yes No
(If client has an Advance Directive a copy if need for file)

My Advance Directive is registered with the Division of Mental Health Services (DMHS). Yes No N/A

Other copies of my Advance Directive are located in the following places: N/A

My therapist and/or service provider explained each of these forms to me and have answered any questions I had about any of the forms.

Print Name _____

Client's Signature _____

Date _____

Therapist/Service Provider Signature _____

Date _____



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CONSENT FOR SERVICES

Client's Name _____

At Family and Children's Services ("FACS"), we strive to provide the highest quality of services possible while striving to protect and enhance the rights and quality of life of all of our clients. You have the right to consent to treatment/services and may withdraw your consent at any time.

In situations where you have been required to receive services, such as by court order or government funded program contract, the referral source will be notified that you are receiving services. They will also be notified if you refuse services or if you choose to withdraw from services once you have begun. Representatives of FACS and the court or government agency which monitors specific programs may share confidential information, including case record information, where required.

I have been informed by my therapist/service provider that all FACS therapists/service providers are supervised in accordance with Agency policy.

I have been advised that services are being rendered by an associate counselor and are done so under the supervision of a qualified supervisor.

I have also been informed that services may include my completion of behavior questionnaires which are used to help determine the best treatment/service plan for me or my child. No identifying information will be disclosed and will remain confidential, in accordance with HIPAA policies.

FOR HOME BASED SERVICES:

Please check the box below giving agency staff member(s) permission to meet with you in your home for an assessment meeting, to discuss potential benefits of services and to see if our services are right for you. This signature also gives permission for agency staff members to meet with you in your home throughout the time that you are receiving services from the agency.

I give permission for staff members of Family and Children's Services to meet with me in my home for the above-stated purposes.

Signature _____

Date _____

ALL CLIENTS MUST SIGN THIS FORM and if CLIENT IS UNDER 18, MUST CHECK AND INITIAL ONE OF THE TWO BELOW OPTIONS:

No one else has parental decision making authority for my child.

I share parental decision-making authority with: _____
Name of co-parent

Address and Phone Number of co-parent _____

I have read the above statements and I consent to receive services from Family and Children's Services. I also realize that I have the right to withdraw my consent at any time. In addition, I acknowledge that I have received the Privacy Notice. Any questions that I have concerning the use and disclosure of my health information have been answered.

Signature of client _____

Date _____

Signature of parent/guardian for minor children _____

Date _____

Signature of witness _____

Date _____

Telemental Health Informed Consent

I _____ (name of client) hereby consent to participate in telemental health with Family and Children's Services as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical healthcare services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental 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 might be entitled.
2. I understand that there are risks and consequences associated with telemental health, 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 session 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 privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health 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 telemental health services are not appropriate, and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we may end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

(TURN OVER)



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EMERGENCY PROTOCOLS

Your therapist needs to know your location in case of an emergency. You agree to inform your therapist of the address where you are located at the beginning of each session. You will also provide a contact name who we may contact on your behalf in a life-threatening emergency only.

My location during telemental health session will be:

My emergency contact person is (name, address, phone):

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.

Signature of client/parent/legal guardian

Date

Signature of therapist

Date



AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Name: _____ DOB: _____
Address: _____

I (we) hereby authorize Family and Children's Services to use or disclose information concerning _____.

To be sent to / or from (circle one or both)

(Name and address of doctor, school, agency, etc.)

The information to be disclosed is (specify information):

The information includes information related to an HIV-related condition, including HIV-related tests, illness, AIDS or any information indicating potential exposure to HIV. I understand that my HIV-related treatment may not occur unless I permit my information to be used or disclosed for payment purposes.

The information includes information related to drug or substance abuse treatment and assessment. I understand that my substance abuse treatment may not occur unless I permit my information to be used or disclosed for payment purposes.

I understand that the foregoing information is to be used for the following purpose (s):

I understand that my consent pertains to the foregoing and automatically expires in (12) twelve months. I understand that I have a right to receive a copy of this form after I sign it, that I have a right to refuse to sign this authorization, and that except as noted above my health care will not be affected by my refusal to sign this form. I understand the nature of the authorization that I have the right to revoke consent at any time by writing to Family and Children's Services, Attn: Compliance Officer, except to the extent that action has been taken upon my authorization.

The information authorized for disclosure may be re-disclosed if the recipient(s) described above is not required by law to protect the privacy of the information.

Limits on Re-Disclosure

If you are authorizing the disclosure of HIV-related information, State law prohibits the re-disclosure of this information without your authorization, or unless permitted by Federal or State law. In cases where drug or substance abuse information is disclosed, Federal law prohibits the re-disclosure of this information without your authorization, unless permitted by Federal or State law. 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 any alcohol or drug abuse patient.

I (we) do not authorize any release of information to any party at this time.

This form should be fully completed before signing

Signature

Date

Relationship to Above

Signature

Date

Relationship to Above

Witness

Date



Acknowledgement and Consent to use Electronic Communication

I. *What is Electronic Communication?*

Electronic communication is any form of email, text messaging, and digital communication of any form to and from an individual utilizing a telephone, cellphone, computer, tablet, digital camera or any other form of digital technology.

II. *Confidentiality and Electronic Communication*

Family and Children's Services (FACS) understands that you may choose to use electronic communication, such as text messaging, to communicate with your clinician. This consent has been created to outline the potential benefits and risks to confidentiality when communicating with a therapist via. E-mail, text message, or any form of digital communication.

- A. **Confidentiality:** The United States legislation passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to provide data privacy and security provisions for safeguarding medical information. In utilizing electronic communication, one's privacy and security may be at risk. Family and Children's Services is ethically and legally obligated to maintain records of all correspondence whether in person, by phone, or via electronic communication such as email or text messaging. FACS will use reasonable means to protect the security and confidentiality of email and text information sent and received. However, because of the risks outlined below, FACS cannot guarantee the security of email and text communication, and is not liable for improper disclosure of confidential information that is not caused by FACS intentional misuse.
- B. **Limits to Confidentiality:** Any matters of safety, such as reports of abuse, neglect, or "duty to warn" situations, are not covered under the laws of confidentiality outlined above. FACS staff are legally required to make reports to the NJ ABUSE Hotline or local law enforcement in the event such disclosures are made, whether in person or through electronic communication.

III. *Potential Risks and Limitations of Electronic Communication*

- A. **Risks and Limitations:** Electronic Communication has a number of risks that clients should consider before using e-mail or text messaging to communicate with your therapist. The following is a list of the potential risks and limitations to using electronic communication.
 - At FACS, we have secure encrypted e-mails, servers and systems. However, outside entities apart from FACS may not.
 - The use of electronic communication does not provide crisis intervention, therapy sessions or any form of clinical assistance to the client.
 - No technology is 100% secure and FACS cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically.
 - Third-party services that feature text messaging or other direct electronic messaging may provide limited security and protection of confidential information.
 - Clinicians are not authorized to have access to agency cell phones outside of agency and individual work hours. Therefore, attempts to contact your clinician outside of agency hours or your clinician's work schedule, will not be answered until the next business day or until your clinician is scheduled to work. FACS maintains an after hour's phone service to speak to an on call employee.
 - FACS is ethically and legally obligated to maintain records of all correspondence whether in person, by phone or via electronic communication such as email or text messaging
 - Information regarding treatment or other personal information should not be communicated through text messaging or email.



- B. Emergencies:** I have been advised and understand any form of electronic communication is to be used for simplifying and expediting scheduling/administrative matters only.
- **Email & texting should NOT be used to communicate:**
 - Suicidal or homicidal; thoughts or plans
 - Urgent or emergency issues (psychiatric or medical)
 - Serious or severe concerns or matters of safety
 - Rapidly worsening symptoms.
 - Changes to treatment plan or personal updates on progress
 - **In a crisis or life threatening emergency clients should:**
 - Call 911, go to your nearest emergency room or contact the following 24/7 hotline:
 - SUICIDE HOTLINE : 1-800-273-8255
 - FAMILY HELPLINE: 1-800- THE KIDS (843 – 5437)
 - NJ DOMESTIC VIOLENCE HOTLINE: 1-800- 572 SAFE (7233)
- C. Electronic Communication Agreement** – The types of information that can be communicated via e-mail/text with your clinician during business hours includes:
- Appointment conformation
 - Late arrival to regularly scheduled appointment
 - Appointment cancelation/Rescheduling

IV. Consent

- A. By signing this consent I agree and understand the following:**
- I agree to the use of email/cell phone texting as needed and understand that electronic communication should only be used for scheduling and administrative purposes, within the guidelines above.
 - If more urgent assistance is needed, I will utilize the crisis services listed under “In a life threatening emergency.”
 - By signing, I, the client (parent/guardian) is not permitted to disclose or post digital or other electronic communications from social workers or other recipients of services without proper consent.
 - I understand that the use of email, cell phone or other forms of technology does not eliminate the option to provide verbal and/or face-to-face communication when changing appointments, last minute updates, or cancellations.
 - I understand that electronic communication is not to be used in place of therapeutic services, and clinical services can only be provided during scheduled in-person sessions.
 - If at any time my therapist or I believe email/texting is interfering in my therapeutic process, being used ineffectively, or in the event of inappropriate conduct (such as threats made towards staff) either party can revoke this consent. Termination of consent must be completed in writing and include the date consent is being terminated as well as signatures of both parties.



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I have opted not to provide consent for electronic communication. I will schedule appointments via phone contact or in person during scheduled sessions.

I have chosen to use electronic communication to coordinate scheduling with my clinician. I have read and fully understand the information provided to me. I have had the opportunity to discuss my questions and concerns with my clinician/FACS staff. I have provided my preferred form of electronic communication below. I understand that standard messaging rates may apply, and that I am responsible for all fees related to use of electronic communication.

Preferred Communication Type		Name of Identified Recipient (Client/ Parent or Guardian)	Initials	Date	Time
Cell Phone A:					
Cell Phone B:					
Email A:					
Email B:					

Client Name: _____

Client's Signature _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date _____

(If client is under 18, parent or guardian must sign consent to allow electronic communication)

Witness Name _____

Witness Signature _____ Date _____

Client Demographic Form

Formulario demográfico del cliente

Date (Fecha): _____ **Name** (Nombre): _____

D.O.B (Fecha de Nacimiento): _____ **Age** (Edad): _____

Address (Dirección): _____

Home Phone (Teléfono de Hogar): _____ **Alternate Phone** (Otro Teléfono): _____

Emergency Contact & Telephone #: (Contacto de Emergencia y numero de telefono): _____

Program (Programa): _____ **Case #** (Número de Caso): _____ **Referral Source** (Enviado Por): _____

Insurance Carrier & Policy # (Seguro y No. de Póliza): _____

(When applicable/Cuando sea aplicable)

Occupation (Ocupación): _____ **Education Level** (Nivel Educativo): _____

Race (Raza): _____ **Gender** (Sexo): **Male / Female** (Hombre / Mujer) **Religious Affiliation** (Religion): _____

Are you comfortable reading and speaking in English? (Please check one)
(Te sientes cómodo leyendo y hablando en inglés?) (Por favor circule uno)

YES NO
 Si No

Is English your primary language? YES NO **If No, what language is your primary language?** _____
(Es el inglés su lenguaje primario?) Si No Si no, cual es su lenguaje primario?) _____

HOUSEHOLD COMPOSITION (COMPOSICIÓN DEL HOGAR)

Please list your information and the information of any children you have:
Por Favor Indique su información y la de los niños que tenga:

	First & Last Name (Primer Nombre y Apellido)	Date of Birth (Fecha de Nacimiento)	Relationship (Tipo de Relacion)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

WHAT IS THE BEST WAY TO CONTACT YOU Cuál es la mejor manera de ponerse en contacto con usted

Telephone (Número de Teléfono) _____ Text Message (Mensaje de Texto) _____

E-mail _____
(E-mail address / Correo electrónico)

Other (Otro) _____
Please Specify (Por favor especifique)

Essential Information / Client Electronic Health Record

Instruction: Please complete this form in its entirety, do not leave any blanks

Today's Date: _ / _ / _

Client's Name: _____ Social Security #: _____

1. Do you have any allergies? If none, write NO KNOWN ALLERGIES (Use 2nd sheet if necessary)

Allergies	Reaction	Severity
		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Fatal
		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Fatal
		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Fatal

2. What medications are you currently taking? If none, write NONE (Use 2nd sheet if necessary)

Name	Dosage	Frequency

3. What is your Smoking status?

If under 13 years old, **Check Box** ; **Skip to Question 4**

- Current every day smoker
- Current some day smoker
- Former smoker
- Heavy tobacco user
- Light tobacco user
- Never a smoker

4. What is your Monthly Household Income? (Check one below) & Write Number of Persons in your Household? # _____

- No Income
- \$ 1 to \$ 150
- \$ 151 to \$ 250
- \$ 251 to \$ 500
- \$ 501 to \$1000
- \$1001 to \$1500
- \$1501 to \$1749
- \$1750 to \$2999
- \$3000 to \$4749
- More than \$4750

5. Are you (or your child) Hispanic or Latino?

- Central American
- Dominican
- Puerto Rican
- Cuban
- Mexican
- South American
- Latin / Other: (Please specify): _____

6. What is your primary language spoken?

- English
- Spanish
- Creole
- Other: _____

7. Are you a veteran?

- Not a Veteran
- Veteran
- Honorable Discharge
- Not Honorable Discharge

8. Is anyone in your (your child's) immediate family currently serving on active duty or retired/separated from the Armed Forces, the Reserves, or National Guard? Yes No

Thank you for completing the Essential Information / Electronic Health Record questionnaire.

Client's Name: _____ Relationship to Client: _____

Clinician's Name: _____