Welcome to Tykes & Teens

To All New Clients,

Hello and welcome to our agency. We hope this letter will serve to answer some questions you might have. Please go over this carefully, we will be happy to answer any questions you might have.

APPOINTMENTS: Our appointments are usually scheduled as recurring appointments, on the same day and time each week. If you miss an appointment and fail to call and notify us, you may not be assured of the same time slot. Typically sessions will last 60 minutes. If you arrive late for an appointment, we will still have to end the session at the originally scheduled time. If you have not arrived within 15 minutes of the start of your scheduled appointment time, we will assume you are not able to keep the appointment, and you may not be able to be seen upon your arrival. If you are unable to keep your appointment and you let us know 24 hours in advance, you will not be charged for the session. Missed appointments, without a 24-hour notice, may be charged to you at the rate of ½ of your regular appointment fee.

PAYMENT FOR SERVICES: Payment is required at the time of service, including co-pays. If you request a copy of your/your child's records, there will be a $1.00 charge per page, with a minimum charge of $5.00, for this service.

CONFIDENTIALITY: By law, all records related to your services are deemed confidential and the information from these records will not be disclosed to any individual or agency without your written, informed consent, and/or as required or permitted by law. Tykes & Teens stores all client records electronically. If you would like us to *release information to* another person or agency, or *request information from* another person or agency, regarding treatment, you must complete and sign an Information Release/Request form.

In some very rare circumstances we may be called upon to testify about you in court. If subpoenaed, we must respond.

If you seriously indicate to us that you intend to harm someone or yourself, we are required to take action to prevent that harm from occurring, including alerting authorities and/or warning the person who is being threatened. We are required by law to report any suspected child abuse and/or neglect.

TEAM APPROACH: We treat the whole child/client; we assess for both mental health and substance use issues.

Your input is essential. On behalf of yourself or your child, if you have any comments, questions, and/or concerns, in regards to treatment or safety, please speak up and inform your therapist or any Tykes & Teens staff.

Please be advised: 1) Tykes & Teens practices Universal Infection Control procedures. 2) Due to the confidential nature of our services, the use of camera cell phones is prohibited by all Tykes & Teens staff, clients, volunteers, and visitors. 3) The Evacuation Route diagram is posted in the Waiting Room; please take a moment to review it. 4) Client/parent and therapist: Dual relationships, social/business interactions, and acceptance of gifts is unethical and discouraged. 5) All Tykes & Teens therapists are licensed, or license eligible and receiving supervision. All student interns are supervised by licensed therapists.

Sincerely,

The Staff of Tykes & Teens, Inc.

Tykes & Teens, Inc.
PRIVACY NOTICE

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

- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released to other healthcare professionals within Tykes & Teens for the purpose of providing you with quality healthcare such as review of your records by your therapist's supervisor.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Tykes & Teens receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care, you have been deemed to be a danger to self or others, or by court order signed by a Judge.
- Your confidentiality will be protected to the highest extent of the law.

Your rights concerning your medical information:

- You may be contacted by Tykes & Teens to remind you of any appointments, healthcare treatment options or other health services that may be of interest.
- If you are contacted by telephone, Tykes & Teens will be identified by name on caller ID systems.
- You have the right to receive confidential communication about your health status.
- Your have the right to review and obtain a photocopy of any/all portions of your healthcare information which Tykes & Teens has created.
- You have the right to make certain changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You will be notified of this Privacy Notice at your first appointment and may request a copy at any time.
- Tykes & Teens is required by law to protect the privacy of its patients. Tykes & Teens will keep confidential any and all patient healthcare information and will provide patients with notice of its legal duties and privacy practices with respect to protected healthcare information.
- Tykes & Teens will abide by the terms of this notice. Tykes & Teens reserves the right to make changes to this notice and will continue to maintain the confidentiality of all protected healthcare information. Patients will be notified either in person or by mail of any changes to this notice.
- You have the right to complain to Tykes & Teens or to the Secretary of the US Department of Health and Human Services, if you believe your rights to privacy have been violated. Complaints to Tykes & Teens must be in writing and must be directed to the Privacy Officer at the address provided below. No adverse action or retaliation will be taken against you for filing a complaint.

For further information about our privacy policies, practices or need to file a complaint please contact: Jeffrey Shearer, Privacy Officer, Executive Director at 772-220-3439, 3577 SW Corporate Parkway, Palm City, FL 34990

For SEFBHN (Southeast Florida Behavioral Health Network) contact: Security Officer Andrew McAllister, Data Liaison, Concordia Behavioral Health, 1717 SE 4th St, Ft. Lauderdale, FL 33316 (305) 514-5228 andrew.mcallister@concordiabh.com

Client Name: _____ Date: _____

Client/Guardian Signature: _____

PRIMARY CARE PHYSICIAN (PCP) CONSENT FORM

Client: _____ DOB: _____ SSN: _____

At Tykes & Teens Inc., we strive to provide the most comprehensive treatment to you and/or your child. Based on this, we are asking that you allow us to notify your PCP that you and/or your child are involved in mental health counseling and/or psychiatric services. This promotes a continuum of care between practitioners who are committed to the care and well being of you and/or your child.

We will communicate with your PCP throughout the course of treatment as the need arises. The other practitioner will be able to do the same. You may also request this at any point in your treatment.

Should you change or add providers, we ask that you notify the clinician working with you so that we may update this information.

****

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____ CITY: _____

STATE: _____ **ZIP:** _____

TELEPHONE # _____ FAX # _____

****

Please <u>select one</u> of the following:

☐ 1). I the client or I the parent/ guardian agree for you to contact the PCP listed above, or for the PCP to contact this provider throughout the course of treatment as needed.

☐ 2. I, or the child I am parent/guardian to, currently do not have a PCP. I understand Tykes & Teens, Inc. recommended I obtain a PCP. I will be referred to the Physicians Referral Program in my area (772-563-4764) if I need assistance with this recommendation. Once obtained, I will notify the clinician assigned to myself and/or my child.

☐ 3. I choose to **<u>NOT</u>** have my PCP or any other medical practitioner involved with my care notified of my or my child's involvement in mental health and/or psychiatric services. I understand this choice will be discussed with me again if I /my child is prescribed medication, or if there is a significant event that warrants medical consultation. I understand that Tykes & Teens, Inc. reserves the right to terminate treatment with an appropriate referral for services elsewhere, if a lack of consent to communicate with my PCP or other medical practitioner may result in harm to me/my child.

This release is valid for the duration of services provided to the client; consent can be revoked at any time in writing. Note: This section can be resigned if rescinding permission for information release.

_____ _____

Client or Parent/Guardian Signature Date

_____

Name

INFORMATION RELEASE REQUEST

Client Name: _____ DOB: _____

Last 4 Digits Social Security #: _____ Therapist: _____

SPECIFIC INFORMATION TO BE RELEASED: (_____ I acknowledge I will be charged $1.00 per page for copies, with a minimum charge of $5.00 for this service.) ☐ Behavioral Health Assessments ☐ Demographic/Contact Information □ Specific information: _____

PURPOSE OR NEED FOR INFORMATION: □ Assessment/ Treatment Planning □ Drug Testing □ Continuity of Care □ Status update(s)/ collateral information □ Other (be specific): _____

I understand that my behavioral health treatment records are protected under the federal regulations covering confidentiality of Drug & Alcohol Abuse Patient Records, 42 Code of Regulations (CFR) Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 & 164, FL Chapters 394 & 397, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I hereby request & authorize Tykes & Teens to release the confidential behavioral health information specified above, to/from the following individual/agency:

NAME: Martin County School District PHONE: _____

ADDRESS: 500 East Ocean Blvd. FAX: _____

CITY, STATE, ZIP: Stuart, FL 34996 E-MAIL: _____

INFORMATION MAY BE RELEASED IN THE FOLLOWING FORM(S): * I understand by approving the release of information in the form of a facsimile (FAX) and/or electronic, confidentiality cannot be assured; and I accept the risks that confidentiality may be breached when faxing and/or electronically releasing information.

(Check the boxes that apply) ☐ VERBAL ☐ WRITTEN ☐ FAX* ☐ ELECTRONIC*

I also understand that I may revoke this consent except to the extent that action has already been taken on reliance if it, and that in any event **this authorization automatically expires after one (1) year from the date of consent, unless otherwise stated** here: **Date, Event, or Condition upon which this consent will expire**: _____

The agencies listed on this release form are not responsible for third party re-disclosure of the authorized information exchanged per this release. **PROHIBITION OF REDISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected pursuant to 42 CFR Part 2, HIPAA regulation 45 CFR, and Florida Statutes 394.4615, Florida Administrative Code 65E5.250, and FL Chapter 397. Any further disclosure is strictly prohibited unless the client provides specific written authorization for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public record law. We will not re-disclose any protected health information received from other parties, that may be present in your record.

COVERED ENTITIES AS THAT TERM IS DEFINED BY HIPAA: must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law 45 CFR §§ 164.502(a)(1).

_____ _____

SIGNATURE OF PERSON TO WHOM RELEASE REFERS (CLIENT) DATE OF CONSENT

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN (IF CLIENT IS A MINOR) DATE OF CONSENT

_____ _____ _____

NAME OF WITNESS SIGNATURE OF WITNESS DATE OF CONSENT

_____ _____ _____

DATE INFO. SENT DATE INFO. RECEIVED DATE OF EXPIRATION

Limited English Proficiency and/or Literacy Level required information to be provided orally: □ ***Yes*** □ ***No***

SIGNATURE OF PERSON WHO ACCESSED FILE: _____

Supporting and strengthening our community through quality prevention, education and social-emotional healing services for children and their families

3577 SW Corporate Parkway, Palm City, FL 34990 (772) 220-3439 FAX (772) 220-3484

SYMPTOMS CHECKLIST FOR KIDS

CLIENT NAME: _____ DATE: _____

Everyone has problems and worries. Read each statement below and put a checkmark in the first box if you worry about this. If it is a bigger problem, put more checkmarks in more boxes. One or two checkmarks would mean it is a little problem for you, many checkmarks would mean it is a big problem for you.

	Small problem → Big Problem
1. I get into bad moods a lot.	☐☐☐☐☐☐☐☐☐☐
2. I feel sad a lot.	☐☐☐☐☐☐☐☐☐☐
3. I feel scared sometimes.	☐☐☐☐☐☐☐☐☐☐
4. I feel like I did something bad.	☐☐☐☐☐☐☐☐☐☐
5. I don't like the way I look.	☐☐☐☐☐☐☐☐☐☐
6. I am worried about getting hurt or beaten up.	☐☐☐☐☐☐☐☐☐☐
7. I am worried about someone in my family.	☐☐☐☐☐☐☐☐☐☐
8. I have bad dreams a lot.	☐☐☐☐☐☐☐☐☐☐
9. I have headaches/stomach aches a lot.	☐☐☐☐☐☐☐☐☐☐
10. I can't stop thinking about my problem.	☐☐☐☐☐☐☐☐☐☐
11. I hurt myself on purpose sometimes.	☐☐☐☐☐☐☐☐☐☐
12. I think my parents are mad at me.	☐☐☐☐☐☐☐☐☐☐
13. I get into trouble at home a lot.	☐☐☐☐☐☐☐☐☐☐
14. I get into trouble at school a lot.	☐☐☐☐☐☐☐☐☐☐
15. I get into fights with other kids.	☐☐☐☐☐☐☐☐☐☐
16. I get teased by other kids.	☐☐☐☐☐☐☐☐☐☐
17. I have an awful secret I'm nervous to share.	☐☐☐☐☐☐☐☐☐☐
18. Somebody is touching me in a way that I don't like.	☐☐☐☐☐☐☐☐☐☐
19. I don't have anyone to talk to about my worries.	☐☐☐☐☐☐☐☐☐☐
20. I don't have anything fun to do after school or on weekends.	☐☐☐☐☐☐☐☐☐☐

Form reviewed by intake therapist: _____ _____

Therapist Signature Date

Survey adapted from Lianna Lowenstein

SYMPTOMS CHECKLIST

(To be completed by clients in Middle and High School)

CLIENT NAME: _____ **DATE:** _____

I CAME TO TYKES & TEENS BECAUSE: _____

Check all **current** problems/symptoms that describe you:

__ I act too young for my age
__ I argue a lot
__ I have trouble paying attention/concentrating
__ I have trouble sitting still
__ I feel lonely
__ I feel confused
__ I cry a lot
__ I am mean to others
__ I daydream a lot
__ I deliberately try to hurt myself
__ I try to get a lot of attention
__ I destroy things
__ I have trouble sleeping
__ I disobey adults
__ I store up things I don't need
__ I don't get along with other kids
__ I don't feel guilty after doing something I shouldn't
__ I am jealous of others
__ I am afraid of going to school
__ I am afraid I might say or do something bad
__ I feel that I have to be perfect
__ I feel that no one loves me
__ I feel that others are out to get me
__ I feel worthless or inferior
__ I accidentally get hurt a lot
__ I get in many fights
__ I get teased a lot
__ I hang around with kids who get in trouble
__ I act without stopping to think
__ I would rather be alone than with others
__ I lie or cheat
__ I have rashes or skin problems
__ I bite my fingernails
__ I have nightmares
__ I am not liked by other kids
__ I feel guilty
__ I eat too much
__ I see or hear things other people don't think are there
__ I am overweight
__ I physically attack people
__ My schoolwork is poor
__ I am clumsy, not coordinated
__ I would rather be with older kids than kids my own age
__ I would rather be with younger kids than kids my own age
__ I refuse to talk
__ I run away from home
__ I scream a lot
__ I am secretive or keep things to myself
__ I am self-conscious or easily embarrassed
__ I set fires
__ I feel sick, nauseous, or vomit
__ I show off or clown around
__ I am shy or keep from getting involved with others
__ I steal things
__ I am stubborn
__ My moods or feelings change suddenly
__ I swear or use dirty language
__ I think about killing myself
__ I talk too much
__ Parts of my body twitch or make nrevous movements
__ I tease others a lot
__ I get angry a lot
__ I think about sex too much
__ I threaten to hurt people
__ I am too concerned about being neat or clean
__ I cut classes or skip school
__ I don't have much energy
__ I am unhappy, sad, or depressed
__ I wish I were of the opposite sex
__ I use alcohol or drugs for non-medical purposes
__ I worry a lot
__ I repeat certain acts over and over
__ I don't eat

Form reviewed by intake therapist: _____ _____

Signature Date

SYMPTOMS CHECKLIST

(To be completed by client's parent/guardian and all adult clients age 18 and over)

CLIENT NAME: _____ **DATE:** _____

Form completed by: _____ **Relationship to Client:** _____

REASON(S) FOR COMING TO TYKES & TEENS:

_____

_____

Problems have persisted for:

□ less than 1 week □ 1 to 4 weeks
□ 1 week to 3 months □ 3 to 6 months
□ 6 to 12 months □ 1 to 2 years
□ chronic

Check all **current** problems/symptoms of the **client** receiving services:

□ guilt
□ crying spells
□ nightmares
□ irritability
□ grief
□ depressed mood
□ fatigue/low energy
□ hyperactive
□ mood swings
□ poor grooming/poor hygiene
□ feelings of worthlessness
□ feelings of hopelessness
□ low self esteem
□ nervousness/anxious
□ avoidant behavior
□ self-injurious behaviors
□ social withdrawal/isolation
□ fidgety
□ sexual abuse victim
□ physical abuse victim
□ emotional abuse victim
□ sexually inappropriate
□ physically abuses others
□ emotionally abuses others
□ poor concentration
□ distractibility
□ poor memory
□ paranoid
□ odd thoughts/beliefs
□ problems getting to sleep
□ problems staying asleep
□ problems waking up
□ repetitive behaviors
□ panic attacks
□ sexual issues
□ obsessions
□ oppositional/non-compliant
□ aggressive behaviors
□ fighting (physical)
□ arguing (verbal)
□ excessive anger
□ property destruction
□ work problems
□ substance/alcohol use/abuse
□ legal problems
□ marital/family/relationship crisis
□ poor peer relationships
□ poor impulse control
□ bedwetting
□ wetting self during the day
□ problems with bowel movements/soiling pants
□ hypochondriac/imagined sickness
□ bingeing/purging /bulimia
□ laxative/diuretic abuse
□ anorexia/self starvation
□ significant weight gain or loss
□ increase/decrease in appetite

Medical Illness:

□ constipation
□ diarrhea
□ nausea/feel sick
□ headaches
□ stomachaches
□ vomiting
□ juvenile diabetes
□ thyroid condition
□ asthma
□ allergies
□ Other: _____

□ hallucinations (sees, hears, feels things that others do not)
□ excessive fears of _____ □ agoraphobia (difficulty leaving house)
□ behavior problems at home –Describe: _____
□ School Issues: □ academic problems □ behavior/conduct problems □ excessive absence □ tardiness
□ skipping school □ refusing to attend school □ suspensions □ referrals
□ Other: _____

List all persons currently living in client's household:

Name	Age	Relationship to client
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Form reviewed by intake therapist: _____ _____

Signature Date

SLIDING FEE SCALE APPLICATION

THIS FORM IS TO BE COMPLETED BY ALL CLIENTS WHO WISH TO APPLY TO HAVE THEIR FEES REDUCED.

Client's Name_____ DOB_____

Please list all household members and all income to the home:

NAME (including client)	AGE	RELATIONSHIP TO CLIENT	Monthly Income (include all income, child support, SSI or SSDI).

Total Monthly Household Income $ _____

If no Income: Who pays rent/mortgage? _____ Who pays bills and buys food? _____

(FOR OFFICE USE ONLY)

Per session: individual / group
SLIDING SCALE FEE $_____/_____ VERIFIED BY_____ DATE_____

Proof of income must be submitted with this application for it to be considered Complete.

The above information is true and correct to my knowledge. I authorize Tykes & Teens, Inc. to verify any of the above information.

ADDITIONALLY, I AGREE TO PAY THE "SLIDING SCALE FEE $" AS OUTLINED IN THIS DOCUMENT. I FURTHER AGREE TO INFORM TYKES & TEENS OF ANY CHANGE IN THE HOUSEHOLD'S FINANCIAL SITUATION. I UNDERSTAND THAT TYKES & TEENS MAY PERIODICALLY, DURING THE COURSE OF TREATMENT, REQUEST "CURRENT PROOF OF INCOME" AND IF THAT "PROOF OF INCOME" IS NOT PROVIDED TO THE SATISFACTION OF TYKES & TEENS, THE FEE FOR SERVICE MAY REVERT TO THE FULL FEE OF $100.00 PER INDIVIDUAL SESSION / $30.00 PER GROUP SESSION .

GUARANTOR'S SIGNATURE _____ DATE _____

GUARANTOR'S NAME PRINTED _____

CLIENT RIGHTS AND PROGRAM RULES AND RESPONSIBILITIES

As a client of this Agency you have the right to:

*Be treated with courtesy, sensitivity, respect and dignity at all times.
*Communicate anything, which is discussed during your session.
*Confidentiality (anything which is talked about in your sessions will be kept in the session by your therapist unless it relates to abuse, homicidal or suicidal thoughts/plan).
*Quality services, in an environment that minimizes distractions that interfere with therapeutic activities.
*Know who is providing services and is in charge of your care.
*Be informed of all treatment planning.
*The right to access, request amendment to, and receive an accounting of disclosures regarding his or her own clinical/service information as permitted under applicable law.
*Call the Department of Children and Families at anytime to report abuse.
*Be treated equally regardless of financial status (the amount of money your family has).
*Take any legal action you feel is justified.
*Be treated without discrimination due to differences in race, color, religion, gender, sexual orientation, marital status, veteran's status, familial status, gender identity or expression, political beliefs, ancestry, age, national origin, genetics, and/or disability.
*Be free from neglect, exploitation, and verbal, mental, physical, and sexual abuse.
*Know what support services are available and there are interpreters if you do not speak English.
*Know what auxiliary aids and services are available if you are deaf or hard-of-hearing.
*Refuse care, unless the law says care must be given.
*Help with any emergency problem that will get worse if help is not provided, including after hours through the on-call.

As a client of this Agency you are responsible for:

* Keeping your appointments and, when unable to do so for any reason, notifying your therapist or the receptionist.
*Assuring that the financial obligations of your healthcare are fulfilled as promptly as possible.
*Telling your therapist, as best you can, all you know about your problem.
*Telling your therapist about any changes in how you feel.
*What happens if you refuse help or do not follow your care plan. If your therapist documents "client refused", you must sign or initial the document.
* Following your Treatment Plan and asking questions when you do not understand something.
* Following the rules and showing respect and consideration for Tykes & Teens staff and property.

If you feel any of the rights listed above have been violated, you may submit a grievance to your treating therapist or to the Executive Director. You will receive a written response to your grievance within five (5) working days. Client Grievance forms are available from the receptionist or underneath the Sign-in sheet on the clipboard in the Outpatient, Jensen Beach, and Hobe Sound offices, from any staff in the ALTOSS Program, or from the guidance counselor in the school setting.

ABUSE HOTLINE 1-800-962-2873
ALCOHOL DRUG ABUSE PROGRAM OFFICE 1-772-595-1315
LOCAL FLORIDA ADVOCACY COUNCIL 1-800-342-0823
HEALTH DEPARTMENT 1-772-221-4000
JOINT COMMISSION 1-800-994-6610 (complaint@jointcommisssion.org)

AUTHORIZATION FOR TREATMENT

The undersigned authorizes the staff of Tykes & Teens, Inc. to provide mental health counseling for themselves, or for the minor listed below if they are signing as the personal representative, and are legally able to seek medical treatment for said minor. The undersigned authorizes the staff of Tykes & Teens, Inc. to communication, including Caller ID, at the telephone number(s) and/or email provided on the Contract for Services for the duration of services.

Name of person who will receive services _____
Please print: First Middle Last

Signature of Guardian _____ Date _____

Signature of Client _____ Date_____
My signature shows that I have been informed of my rights and responsibilities and that I understand this information.

Signature of Provider _____ Date _____
My signature indicates that I have explained the above statement to the client and have offered a copy of this form.

TYKES & TEENS, INC.
CONTRACT FOR SERVICES

The standard charge for each individual session is $130.00 per 60 minutes and $30.00 per group session. We accept Medicaid and most insurance. If we are billing Medicaid on your behalf and your benefits end, you must notify our office immediately. Any required payments/co-pays may be made by check, cash, or money order and are expected at the time of the service, we suggest you make your payment at the time you sign-in for your appointment. Although we bill insurance companies (or other payor sources) as a courtesy to you, if your insurance company or other payor source pays less than anticipated or denies the claim, you will be responsible for payment of services rendered. Missed appointments, for which you failed to provide 24-hours notice, may be charged to you at the rate of ½ of the regular appointment fee. We only go to court if we are subpoenaed; if subpoenaed and required to attend, the cost of the testimony/deposition is a minimum of $240.00, payable in advance and non-refundable. If the request to appear in court is cancelled less than twenty-four (24) hours before the schedule court time, there will be no refund. Subsequent to the first hour of testimony, each additional hour will be billed at the rate of $120.00 per hour, this includes travel and wait time (portal to portal). Following the testimony/deposition, the remaining balance will be due by the requestor immediately. If you request a copy of your/your child's records, there will be a $1.00 charge per page, with a minimum charge of $5.00 for this service.

When no insurance is available, and there is a financial need, we offer a **sliding fee scale,** which is based on total income to the home along with the number of dependents living in the home. **Proof of income must be provided as part of the sliding scale application. An application without proof of income will not be accepted.** An acceptable proof of income is your last year's tax return or estimated tax return. If you would like to apply for the sliding fee scale and have not already been provided with a "Sliding Fee Scale Application," please request one prior to signing this contract. Due to the funding requirements for your counseling, unless you are paying the full fee ($100.00 per session), we are now required by Martin County Children's Services Council, the Children's Collaborative, SAMH, Medicaid, and Devereux (the organizations that fund our services), to provide measurable treatment data on all clients in an effort to prove effectiveness of treatment. We have been informed that this information will be limited to this purpose. Due to the confidential nature of the information that we are required to provide, we need your consent to release this data. If you do not feel comfortable releasing this information or you choose to revoke your consent, that is your right; however, we may not be able to offer you the full extent of our sliding fee scale. If you have any questions concerning these issues, please feel free to discuss this with your therapist.

The signer of this contract is considered the guarantor of this account and agrees to assume financial responsibility for any payments outlined above. (This would typically be either the client, or in the case of a client who is under the age of 18, the parent or legal guardian. Foster parents will not be charged for sessions provided to foster children for which Medicaid fails to pay.)
Please Print Client Information:

Name: _____ Date of Birth: _____
First Middle Last
Street Address: _____ City _____ State _____ Zip_____

Telephone Contact Number: ( ) _____ Social Security Number: _____
area code
School _____ (Grade):_____
I authorize release of any medical information, or other information required by the payer of the claims, or by the insurance company processing claims related to services provided by Tykes & Teens, Inc. I also authorize payment of these medical benefits to: Tykes & Teens, Inc. Additionally, I consent to the release of information described above. This consent is valid for the duration of services. I may revoke my consent at any time upon delivery of written notice to Tykes & Teens, Inc. I understand that the termination of consent will be effective upon the delivery of said notice to Tykes & Teens, Inc., but excludes information already furnished before that date. No further disclosure of this information is permitted unless the authorizing parties sign another request.

Please Print Guarantor/Emergency Contact Information:

Name: (First) _____ (Last) _____

Email: _____ Address same as above? Yes_____ No _____ (If no, please complete):
Please submit billing via email: yes/no
Street address: _____

City _____State _____Zip_____ Phone# ( ) _____

Relationship to Client: _____ Employer: _____

Employer's address _____ (work phone #) ( ) _____

Guarantor's Date of Birth_____ Social Security Number_____

Guarantor's Signature: _____ Date: _____

(If there is a 2nd guarantor (such as another parent) a separate contract must be signed by that party.
Limited English Proficiency and/or Literacy Level required information to be provided orally: □ Yes □ No