SOCIAL CARE SERVICES, LLC

Phone (904) 294-5329 **Fax** (904) 485-8460
SocialCareServices.NET
SCSIntakes@gmail.com

INTAKE FORM

Date: _____

Patient Name: _____

Social Security #: _____ **Gender:** _____ **Date of Birth:** ____/____/____ (MM DD YEAR)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Alternate Phone:** _____

Email: _____

Legal Guardian: _____ Relationship to Patient: _____

Address (if different from above): _____

Legal Guardian: _____ Relationship to Patient: _____

Address (if different from above): _____

**If applicable, guardians must provide all court documents pertaining to joint custody. Attached? □Yes □No*

Insurance Carrier: _____

Insurance ID: _____ Group No.: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

In case of emergency, notify: _____

Phone: _____ Relationship: _____

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CONSENT TO MENTAL HEALTH SERVICES

As a Client of Social Care Services, LLC, I recognize my responsibility to:

1. Participate in the treatment program and therapeutic activities in the Treatment Plan I sign.
2. Not engage in assaultive or destructive threats or behavior towards Social Care Services staff, visitors, property, or other clients. I understand that such treatments or behaviors may constitute grounds for dismissal from treatment and/or possible criminal prosecution and/or civil suit.

Client Name (Print)

Client Signature (if over 18) or Parent/Legal guardian

Date

SOUTHSIDE (MAIN OFFICE)
8833 Perimeter Park Blvd
Suite 201
Jacksonville, FL 32216

ORANGE PARK
1857 Perimeter Park
Suite 106
Orange Park, FL 32607

NORTHSIDE
550 Balmoral Circle
Suite 204
Jacksonville, FL 32218

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NO SHOW AND CANCELLATION POLICY

$25 NO SHOW/Cancellation Fee
is the sole responsibility of the patient

Patients who schedule clinic appointments and fail to keep them have a negative impact on patient care and productivity. The No Show process is designed to minimize disruptions in the scheduling process and disruptions in delivery of care. The No Show process is ultimately intended to improve both the health and quality of life of our patients by increasing access to care.

NO SHOW and appointments cancelled with less than 24 hours' notice are subject to a $25.00 cancellation fee.

Patients who do not show up for their appointment will be considered a NO SHOW.

Cancellation Fees and NO SHOW Fees are the SOLE RESPONSIBILITY of the patient and must be paid in full before the patient's next appointment.

Our practice firmly believes that good physician/patient relationship is based upon under

_____
Client Name (Print)

_____ _____
Client Signature (if over 18) or Parent/Legal guardian Date

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Consent for Communications

Client Name: _____

Date of Birth: _____

By signing this form, I authorize Social Care Services to send automated text messages to my cell phone, leave voicemail, and/or send email.

We use this information strictly for the purposes of communicating with you more efficiently. We do not sell share or rent our users'personally identifieable information unless required by law, and we do not send email or other communications without your permission. We never send spam.

Please communicate with me by:

◯ Email: _____
(Print email address)

◯ Text: _____
(Cell phone number)

◯ Voicemail: _____
(Phone number)

_____ _____
Client Signature (if over 18) or Parent/Legal guardian Date

Social Care Services, LLC

Informed Consent for Medication Administration

It has been explained to me that some medications that are administered for my condition may cause extra pyramidal symptoms, which may manifest as tremors, muscle spasms, tics and tardive dyskinesia.

I understand I have the choice to discontinue medication but would rather not risk decompensation of my psychiatric condition and thus will consent to stay on medication, risking the above side effects.

A warning was recently given to atypical antipsychotics that can elevate lipid levels, cholesterol levels, as well as cause weight gain which can eventually lead to diabetes. If the patient has diabetes, please notify the physician.

Instructions for prescribed medications was given, explained to the client and/or parent/legal guardian and was accepted by client and/or parent/legal guardian.

Client Name (Print)	
Client Signature (if over 18) or Parent/Legal guardian	Date
Witness	Date

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SYMPTOM CHECKLIST

(Check all that apply.)

Client Name _____ Date _____

□None □Stealing □Truancy □Imprisoned
□Arrests □Destroys Property □Conduct problems □Cruelty to animals
□Fire setting □Convictions □Uses assumed names □Frequent lying
□Family destruction □Running away from home □Insomnia □Overeating □Suicidal ideations
□Suicidal attempts □Homicidal ideations □Lack of motivation □Fatigue □Depressed mood
□Manic episodes □Grief □Family problems
□Loss of interest □Excessive energy □Impulsivity □Irritability □Racing thoughts □Crying spells
□Risky Activity □Hallucinations □Delusions □Anxiety □Poor concentration □Forgetful
□Unable to communicate age-appropriate needs/wants/feelings (explain): _____

_____

□Non-compliant with rules □Physically abusive □Verbally aggressive
□Exhibits repetitive behavior □Isolates from environment
□Inappropriate behavior (explain): _____

_____

□Any symptoms not listed above: _____

_____

Is the client taking any medication? □YES □NO

Please list all medications: _____

_____

_____

_____

_____

What areas would client like to work/focus on during treatment: _____

_____

_____

_____

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FMLA POLICY

At Social Care Services, we understand that situations arise in which you must take a leave of absence from work due to physical/emotional issues. It is the policy of Social Care Services to *consider* completing FMLA paperwork if the following conditions are met:

- Client requesting paperwork is required to have attended regularly scheduled counseling sessions from Social Care Services for a minimum of 6 months.
- Paperwork must be completed in person during a scheduled appointment.
- A fee of $425 must be paid for each occurrence of FMLA paperwork completion. This fee is the client's individual responsibility and must be paid prior to paperwork being completed.

Our practice firmly believe that good physician/patient relationship is based upon understand and good communication. Questions about FMLA fees should be directed to the front desk.

_____

Client Name (Print)

_____ _____

Client Signature (if over 18) or Parent/Legal guardian Date