Ruth & Norman Rales
Jewish Family Services
Help. Hope. Humanity.

THERAPY

INITIAL ASSESSMENT

Forms Package

(Updated 10/04/2018)

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Rev. 10/2018

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

[JFS File Original]

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up with other healthcare providers who may be involved in my care directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessment and improvement, business management and general administrative activities.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Ruth & Norman Rales Jewish Family Services, Inc. has the right to change its Notice of Privacy Practices and that I may contact this office at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name (Print)	**Parent or Legal Guardian Name (Print)**
Signature of Client	**Signature of Parent or Legal Guardian**
Date Signed	**Relationship to Client**

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Rev. 11/2013

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

[CLIENT Copy]

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up with other healthcare providers who may be involved in my care directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessment and improvement, business management and general administrative activities.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Ruth & Norman Rales Jewish Family Services, Inc. has the right to change its Notice of Privacy Practices and that I may contact this office at any time to obtain a current copy.

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Client Name (Print)	Parent or Legal Guardian Name (Print)
Signature of Client	Signature of Parent or Legal Guardian
Date Signed	Relationship to Client

CLIENT COPY

(Leave This Copy With Client)

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Behavior Support & Management (BSM) Practices and Consent Form

Philosophy and Organizational Policy:

Ruth & Norman Rales Jewish Family Services, Inc. (JFS) promotes a safe and therapeutic environment and will provide necessary supports and resources to keep staff and service recipients safe. The agency prohibits the use of any restrictive behavior management intervention, including locked seclusion, manual, mechanical or chemical restraints. Any non-restrictive behavior support practices used must comply with federal, Florida and local requirements.

When dealing with a client who exhibits any behavior that may place the client, other clients and/or staff at risk (e.g., verbally abusive, threatening, or physically violent clients), the agency staff might be required to employ behavior support management techniques to foster adaptive, appropriate and pro-social behavior and assure the safety of the client, other clients and/or the staff. When client's behavior places him/herself and/or others in harm's way, behavior management techniques are to be utilized. For this agency, these behavior support management techniques are limited to verbal persuasion/interventions.

Hence, when the agency becomes concerned with the safety of its clients and/or personnel, it must advocate and practice a policy of behavioral support management that should:

- Practice behavior support management techniques designed to de-escalate the situation and foster positive behavior. Such techniques are utilized exclusively for the purpose of behavioral control. Behavioral support techniques are to be used to appropriately reduce excessive negative behavior.
- Employ the least intrusive method possible to assure the safety of all parties concerned (i.e. the client, other clients and staff)

By signing this document, I:

1. Acknowledge that I have read the above statements:
   - ☐ CONSENT to the BSM philosophy and practices of JFS
   - ☐ DO NOT CONSENT to the BSM philosophy and practices of JFS.
2. Acknowledge that I have a right to refuse consent to treatment based on the behavior support management of JFS but that JFS may determine that I cannot be served as a result of this refusal.
3. Acknowledge that any instances of behavior that prevents JFS from maintaining a safe and therapeutic environment, could lead to cessation of services from JFS.
4. Acknowledge that this form is effective for a period of one year.

_____ _____

Client Signature or Parent Signature Date

If the individual signing this form is not the client, please designate whether the person signing is a parent or legal guardian:

☐ Parent ☐ Legal Guardian NAME:_____

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

CLIENT GRIEVANCE PROCEDURE

Rev. 10/18

[JFS File Original]

Ruth & Norman Rales Jewish Family Services (JFS) is extremely cognizant of the importance of establishing a grievance system that can effectively and quickly respond to the concerns and complaints of its clients. The objectives of this system are as follows:

1. To promote open lines of communication between clients, agency staff members and administration through which any problem may be fully explored and resolved in the best interest of all concerned.
2. To provide specific information to management on a systematic basis, which may result in a review and adjustment to the method of service delivery and/or other aspects of program operations.
3. To promote a positive relationship between clients and providers relative to the overall functioning of the agency's services.

The Grievance Procedure is intended to give the client a hearing particularly when he/she is dissatisfied about the nature, quality or delivery of services which are being provided or which are proposed to be provided under the treatment plan. This also holds true when the agency intends to take action that would terminate, suspend or reduce services that are being received.

The Grievance Procedure will strive for expeditious resolution of grievances at the lowest possible level (i.e., direct communication between the parties involved). Requests may be submitted in writing, verbally via telephone or in person. This Grievance Procedure recognizes that there may be two types of complaints. One may be somewhat informal and be related to matters of procedure or clarifying agency policies. Those kinds of grievances do not require a formal, written process and are best handled informally. However, the second type of grievance is formal.

Examples of this kind of complaint from a client include the expression of concerns that the agency or its representatives have been in violation of his / her rights, agency policy, ethical standards, provided service at a lower level than expected or has breached the confidence of the client.

Once a formal grievance is received, the client will be sent a detailed copy of the Grievance Procedure and requested to file a written grievance. Whether the client chooses to file a written formal statement or not, the agency and its representatives will treat the grievance seriously and will document and place in the case file in writing all of the following that apply. In addition, should the client choose to request assistance from a third party, JFS will honor that request.

Therefore, in the steps below, the use of the term "client" is understood to be inclusive of the client and any third party that the client chooses to involve.

Step 1 Discussion of complaint with the staff person involved.

If not resolved or if either the client or the staff person involved prefer, the matter will be brought to the attention of the staff person's immediate supervisor.

Step 2 Discussion with the appropriate departmental supervisor.

The departmental supervisor will speak to the client regarding the complaint. All attempts to reach a resolution will be made. The departmental supervisor will discuss the issue with the subordinate involved and may review the client's files and or engage in other such research as he / she deems appropriate to understand and resolve the issue. If a resolution is reached, a follow-up letter will be sent within five (5) working days to verify details of the resolution. If not resolved, the matter may proceed to the next level.

If the client at any time feels that he / she needs to go further up the organizational ladder, the matter will be referred to the next ranking professional who may be either a department head or the President & CEO. The client must receive courteous and prompt responses and at each step, the contacts with the client must be documented in writing and placed in the client's file, including any and all correspondence with the client about resolving the issue at hand.

If the grievance is filed against a supervisor, then all of the above steps take place except that step one will be between the client and the supervisor and step two will be between the person to whom the depart supervisor reports and the client.

In some cases, the complaint or issue may have broader agency implications. Where that is the case the President & CEO will discuss with the Quality Improvement Management Team.

In no event should an issue go unresolved for more than 30 days, with the majority of them being handled within 10 business days.

Step 3. In addition to the above, at a minimum, grievances that have required either a peer review or consideration by the President & CEO will be presented to Programs Committee and/or other leadership of Board of Directors for appropriate board follow-up.

At any step in the Grievance Procedure, the client may consult with, involve and / or bring a family member, significant other or advocate into the process. Help will be provided in obtaining this assistance without any questions being asked. In addition, contact numbers for the Client Advocacy Program of the Mental Health Association and the local chapter of the Alliance for the Mentally Ill are posted for easy reference on the "Welcome to the Jewish Family Services" brochure. Contact numbers will also be provided for Adult Protective Services, Legal Aid, and the Lawyers Referral Service upon request. Throughout this process, the client will be given the option to consult with these advocacy groups.

In addition, under no circumstances will the agency or any of its personnel terminate services as a result of a grievance.

At all points in the outcome deliberation involving any grievance, the rights and professional integrity of the professional will also be protected.

I acknowledge that I have received a copy of the Client Grievance Procedure form:

_____ _____

Signature Date:

If the individual signing this form is not the client, please designate whether the person signing is a parent or legal guardian:

☐Parent ☐Legal Guardian NAME:_____

[JFS File Original]

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

CLIENT GRIEVANCE PROCEDURE

Rev. 10/18

[CLIENT COPY]

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In addition, under no circumstances will the agency or any of its personnel terminate services as a result of a grievance.

At all points in the outcome deliberation involving any grievance, the rights and professional integrity of the professional will also be protected.

I acknowledge that I have received a copy of the Client Grievance Procedure form:

Signature _____ Date: _____

CLIENT COPY

(Leave This Copy With Client)

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Rev. 10/18

CLIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Client Name: _____

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: _____
- ☐ O.K to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K to mail to home address
- ☐ O.K to mail to my work/office
- ☐ O.K. to fax to this number

☐ Work Telephone: _____
- ☐ O.K to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other: _____
_____

_____ _____ _____

Client Signature (Parent or Legal Guardian) **Print Name** (Parent or Legal Guardian) **Relationship to Client**

_____

Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requires for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Disclosures of PHI for non-TPO reasons will require a separate signed authorization.
Healthcare entities must keep records of *PHI* disclosures, information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and Disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

DATE	Disclosed To	(1)	Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment P=Payment Information
(3) Enter how disclosure was made: F=Fax P=Phone E=E-Mail M=U.S.Postal Service O=Other

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Rev. 10/2018

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ **Phone: _____**

Address: _____ **City: _____ State: FL Zip:**

Date of Birth: _____ **Social Security #: _____**

SECTION A: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:
Ruth & Norman Rales Jewish Family Services
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Persons/organizations receiving the information:
_____
_____
_____

Specific description of information (including date(s)):
_____
_____
_____

SECTION B: MUST BE COMPLETED ONLY IF A HEALTH PLAN OR HEALTH CARE PROVIDER HAS REQUESTED THE AUTHORIZATION

1. *The health plan or health care provider must disclose/provide the following request (attach documentation when applicable):*
   a. *What is the purpose of the use or disclosure?*
      _____
      _____

2. *The patient or the patient's representative must read and initial the following statements:*
   a. *I understand that my health care and payment from the health plan will not be affected if I do not sign this form.*
      Initials: _____
   b. *I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.*
      Initials: _____

SECTION C: MUST BE COMPLETED FOR ALL AUTHORIZATIONS:

The client or the client's representative must read and initial the following statements:

1. *I understand that this authorization will expire on _____/_____/_____(DD/MM/YR) Initials: _____*
2. *I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any actions they took before they received the revocation.* ***Initials***_____

Signature of Client or Client's representative	***Relationship to Client***	***Date***
Printed name of Client or Client's representative	***Relationship to Client***	***Date***

I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations (chemical abuse/addiction clients), and Florida Statutes 294.459 (9b) and/or 90.503 (psychiatric/psychological information), and that disclosure of this information without my additional written authorization is prohibited. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent will automatically expire six (6) months after the date of this consent or on the following earlier date, event or condition.

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

ALL SERVICES Revised: 10/2018

Statement of Client Rights and Consent to Service

I (we) authorize a professional representative of Ruth & Norman Rales Jewish Family Services, Inc. to provide services for myself and/or members of my family as deemed professionally necessary. Services may include any of the following: treatment planning, psychological evaluations including but not limited to psychological testing, diagnosis, care plans, psychiatric evaluations and medication management, assistance and service provisions. I (we) understand that agency professional staff may be consulted with regard to my case.

As a client of this agency you are both welcomed and entitled to:

1. Ask about our professional qualifications and the agency policies and procedures to protect your privacy and confidentiality to the fullest extent possible under Florida law.
2. Know that with a valid court order information contained in your case record may be subject to disclosure even without your consent in accordance with Florida law.
3. Be aware that Jewish Family Services is required by law to inform Department of Children and Families if there is any suspicion of physical, sexual, or emotional abuse and/or neglect of a child. We are also required by law to inform Adult Protective Services, Department of Elder Affairs, if there is any suspicion of physical abuse of a dependent adult.
4. Understand that if your mental health professional or case manager has a reasonable cause to believe that you are a danger to yourself or to the person or property of someone else, then disclosure must be made to an appropriate individual or agency that can prevent the threatened danger.
5. Receive competent, quality services without discrimination because of race, color, creed, age, religion, national origin, economic status, sex, disability, or method of payment.
6. Participation in the development, revision and termination of a service plan that utilizes methods to address your needs as quickly and effectively as possible, and be informed of all services to be provided, and when and how services will be provided.
7. Have sessions in an environment that is most suitable to you with a professional who is prompt, attentive and willing to listen.
8. Refuse any portion of the service plan, or request a change in your assigned staff member without risking the loss of other agency services after being fully informed of and understanding the consequences of such actions.
9. Have your complaints, problems and suggestions heard and given a response.
10. Know that it is possible that your case record may be reviewed by our accreditation and funding sources and Quality Improvement Committee for the purpose of evaluating our services to you.
11. Know that the written case record is kept for seven years. The information is then destroyed by shredding or burning.

Should you feel that your client's rights have not been respected, please discuss this first with the professional staff member assigned to you. If this does not satisfactorily resolve the problem, you are encouraged to contact the Director, Programs and Services. If you are still not satisfied, contact the Executive Director and a scheduled interview will take place within ten (10) working days.

PLEASE NOTE: When a minor under the age of 18 years comes to JFS for treatment, the agency requires a parent or guardian to sign a "Statement of Client Rights and Consent to Service" form which allows JFS to treat the minor. Unless legal documentation stating otherwise is submitted, JFS shall assume that, the parent or guardian signing the "Consent to Service" form has the legal authority to make parental decisions on behalf of the minor. JFS shall be released from any and all liability and shall be held harmless from any and all claims related to a parent or guardian signing a "Consent to Service" form.

I (we) have read and do understand the information regarding my (our) rights as a client(s) of Ruth & Norman Rales Jewish Family Services, Inc.

_____ Date: _____
Client Signature

_____ Date: _____
Signature of Parent, Legal Guardian, or Power of Attorney

_____
Relationship to Client

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Written Statement of Purpose(s) for Collection of Social Security Numbers

Pursuant to Ch. 119 of Florida Statute, Ruth & Norman Rales Jewish Family Services, Inc. is required to inform clients in writing the purposes for which it collects Social Security numbers. Ruth & Norman Rales Jewish Family Services, Inc. collects the Social Security numbers of applicants or recipients of its programs and services for the following purpose(s):

- To determine eligibility and to assist individuals with applications for publicly-funded programs and services.
- If applicable, to share information with the Florida Department of Elder Affairs, Florida Department of Children and Families and/or the Florida Department of Health for purposes of Medicaid funding.
- For identification of clients.

Ruth & Norman Rales Jewish Family Services, Inc. strictly adheres to Federal and State guidelines in keeping information confidential and shares information for stated purpose(s) above when applicable to client services. Responsible steps are taken to protect consumer personal information.

I acknowledge that I have read the above.

_____ _____

Signature of Client/Consumer Date

_____

Printed Name of Client/Consumer

RUTH & NORMAN RALES JEWISH FAMILY SERVICES
POLICY ON
INSURANCE DEDUCTIBLES

DEDUCTIBLE

A deductible amount is the pre-defined amount paid each year by a health plan enrollee before plan coverage begins. When an enrollee or covered dependent sees a provider In-Network or Out-of-Network a deductible most often, does apply. Certain plans may also have co-payments/ and or co-insurance. Client is responsible for deductibles prior to the insurance making any payments for the year. Clients are responsible to understand their insurance policy coverage.

Questions should be addressed to the enrollee's plan coordinator or insurance company.

Different employer contracts will have different client deductibles depending on many variables with the insurance company. You should always be involved and educated to your specific insurance plan and deductible amounts. It is advisable for you to call your insurance carrier and review this information. If you have not spoken with your insurance prior to having been seen at the agency, you should still call and verify as soon as possible to understand your insurance pay structure and deductible.

Ruth & Norman Rales Jewish Family Services sends claims to a client's insurance as a courtesy when non-participating. Claims are always submitted to participating insurance plans.

Clients are responsible to Ruth & Norman Rales Jewish Family Services for the amount of money the insurance applies toward the yearly deductible.

Clients may also be responsible for payment of any co-insurance amounts with participating plans and/or sliding fee co-payments that have been pre-determined by either a Fee Consultant or Therapist/ Doctor with either participating or non-participating plans.

You are responsible for your services to be paid.

You as a client of Ruth & Norman Rales Jewish Family Services are to sign a service payment agreement with the agency and are to sign #3 on the agreement explaining further about deductibles.

Ruth & Norman Rales Jewish Family Services does collect from the client and / or responsible family member deductibles.

Ruth & Norman Rales Jewish Family Services is advising all clients and / or responsible family member to be educated regarding their specific insurance plan. Clients will be billed for deductibles when applicable.

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Rev. 10/2018

EMERGENCY AUTHORIZATION/INFORMATION

DATE: _____

Child's Name_____, _____, _____ Phone: _____
(Last) (Middle) (First)

School: _____

Gender: _____ Date of Birth _____ Grade: _____

Address: _____ City: _____ State: _____ Zip: _____

Doctor's Name: _____Phone:(____)_____

Dentist's Name: _____ Phone:(____)_____

Hospital of Choice: _____Phone:(____)_____

Allergies/Medical Conditions: _____

Medications: _____

I AUTHORIZE EMERGENCY MEDICAL CARE FOR MY CHILD IN THE EVENT OF SERIOUS ILLNESS/ACCIDENT WHEN I CANNOT BE REACHED:

PARENT'S SIGNATURE (OR LEGAL GUARDIAN): _____

RELATIONSHIP TO CHILD IF OTHER THAN PARENT_____

WITNESS: _____ DATE: _____

EMERGENCY PHONE NO: _____CONTACT NAME: _____

MEDICAL INSURANCE: _____RELATIONSHIP TO CHILD: _____

SUBSCRIBER NAME: _____POLICY #: _____

Parent#1 Name: _____ **Parent#2** Name: _____

Business Phone: _(_____)_____ Business Phone:(____)_____

Cell Phone: _(_____)_____ Cell Phone:(____)_____

Beeper: _(_____)_____ Beeper:(____)_____

Please list names of persons who are authorized to pick up your child:

Name:_____Relation:_____Phone:(____)_____

Name:_____Relation:_____Phone:(____)_____

Name:_____Relation:_____Phone:(____)_____

Name:_____Relation:_____Phone:(____)_____

IMPORTANT: PLEASE NOTIFY RUTH & NORMAN RALES JEWISH FAMILY SERVICES IMMEDIATELY IF THERE ARE ANY CHANGES MADE REGARDING THE ABOVE INFORMATION. THANK YOU.

Ruth & Norman Rales Jewish Family Services, Inc.
21300 Ruth & Baron Coleman Blvd.
Boca Raton, FL 33428

Rev 10/2018

Service Payment Agreement

CLIENT NAME: _____ DATE: _____
ADDRESS: _____ DOB: _____
_____ PHONE : _____

$ _____Testing Fee $ _____ On-going Session Fee

In signing this document, I agree to pay for services provided to me and/or my family by the staff of Ruth & Norman Rales Jewish Family Services, Inc. and to abide by the following conditions:

1. If I have Medicare, I agree to allow Medicare to be billed for the full fee allowable by law for covered services. I agree to pay Ruth & Norman Rales Jewish Family Services, Inc. directly for the co-insurance or pre-determined sliding fee and any deductible amount. If I have an approved Madigan coverage as a supplement to Medicare, I may be balanced billed after insurance payments for any deductible amounts or denials.

2. I agree to assign benefits for covered services at the full fee rate to Ruth & Norman Rales Jewish Family Services, Inc. I am responsible for the out of pocket deductible amount, any co-insurance and/or sliding fee and the insurance payment for total cost of service for a therapy session**. Should the insurer send payment intended for Ruth & Norman Rales Jewish Family Services, Inc. to the policy holder, the policy holder agrees to endorse and forward the payment for services to Ruth & Norman Rales Jewish Family Services, Inc.**

3. If I have not met my deductible for any insurance (including Medicare), I agree to pay Ruth & Norman Rales Jewish Family Services, Inc. the full fee for services until deductible is met, unless other arrangements are contracted separately from the sliding fee.

⇨ **I have received "Policy on Insurance Deductible" form. Signature: _____**

4. I understand that once my insurance coverage is exhausted, my sliding scale session fee will go into effect until my insurance coverage is resumed.

5. I agree to pay for services rendered at the time of my appointment. I will pay any past due amounts the day of my appointment.

6. If I do not have insurance at the time of signing this agreement, but acquire insurance at any time while being a client at Ruth & Norman Rales Jewish Family Services, Inc. I will immediately forward insurance information, and all conditions of this contract become effective.

7. At any time during the course of having services provided by Ruth & Norman Rales Jewish Family Services, Inc. should my financial status change, my sliding fee will be reviewed and may change according to new information.

8. I understand that upon continued failure to pay an outstanding balance, Ruth & Norman Rales Jewish Family Services, Inc. may take actions that can result in the collection of these funds. I will bear the full costs of any legal fees and expenses incurred in that collection. I agree that the venue for any such legal action shall be in Palm Beach County, Florida, and that Florida law shall govern.

9. I accept the right of Ruth & Norman Rales Jewish Family Services, Inc. to change its listed fees upon thirty (30) days written advanced notice to me. I further understand that this Agreement does not obligate Jewish Family Services to provide services if I have not fulfilled my obligations as a consumer or if, in the judgment of the agency, the needed services cannot be furnished by existing personnel to an acceptable level of quality, satisfaction and effectiveness.

10. I understand that I will be responsible to pay for appointments that are **not cancelled** with at least **one work day notice**. **Signature:** _____

11. I understand that it is my responsibility to have obtained pre-certification or authorization prior to my first appointment if necessary by my insurance plan. Failure to obtain information will result in full payment being due for session(s). **Signature:** _____

12. I understand that the fee for counseling is based on:
    - $125.00 per 45 minute session
    - $150.00 per 53 minute or longer session **Signature:** _____

I HAVE CAREFULLY READ THE ABOVE PROVISIONS AND UNDERSTAND THEM. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS WHICH WERE SATISFACTORILY ANSWERED. I UNDERSTAND THAT SIGNING THIS AGREEMENT MAKES ME LEGALLY OBLIGATED TO PAY RUTH & NORMAN RALES JEWISH FAMILY SERVICES, INC. FOR SERVICES RENDERED TO ME AND REQUESTED BY ME ON MY BEHALF.

CLIENT SIGNATURE: _____ DATE: ____/____/____

PARENT/GUARDIAN: _____ DATE: ____/____/____

WITNESS SIGNATURE: _____ DATE: ____/____/__

Ruth & Norman Rales
Jewish Family Services
Help. Hope. Humanity.

☐ Counseling Service
☐ Case Management CL __ HO __ VO __
☐ Financial Assistance
☐ Volunteer Recipient Service
☐ Food Pantry
☐ Transportation

REGISTRATION FORM

CLIENT INFORMATION:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #

STREET ADDRESS/P.O. BOX	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

SEX ☐M ☐F	MARITAL STATUS ☐M ☐W ☐S ☐D	RELIGION

EMAIL ADDRESS ☐YES ☐NO Would you like to receive agency information?	RELATIONSHIP TO RESPONSIBLE PARTY ☐SELF ☐SPOUSE ☐PARENT ☐CHILD ☐OTHER

EMPLOYER	EMPLOYER STREET ADDRESS	CITY	ZIP

PRIMARY PHYSICIAN	NAME OF CUSTODIAL PARENT

RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #

STREET ADDRESS/P.O. BOX	CITY	STATE	ZIP

EMAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE

EMPLOYER	EMPLOYER STREET ADDRESS	CITY	ZIP

EMERGENCY CONTACT: (Person not living with you)

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐M ☐F	EMPLOYER

POLICY HOLDER BIRTHDATE	POLICY NUMBER	RELATIONSHIP TO PATIENT ☐SELF ☐SPOUSE ☐PARENT ☐CHILD ☐OTHER	WORK PHONE

SECONDARY INSURANCE:

SECONDARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐M ☐F	EMPLOYER

POLICY HOLDER BIRTHDATE	POLICY NUMBER	RELATIONSHIP TO PATIENT ☐SELF ☐SPOUSE ☐PARENT ☐CHILD ☐OTHER	WORK PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

1. ☐ Family 2. ☐ Friend 3. ☐ Physician 4. ☐ Advertisement – Ad source: _____
5. ☐ Website: _____ 6. ☐ Other: _____

PLEASE COMPLETE THE REVERSE SIDE

PLEASE REVIEW AND SIGN:

I hereby authorize Ruth & Norman Rales Jewish Family Services, Inc. to apply for Medicare/Medigap, and other health insurance benefits on my behalf. I request payment of Blue Cross/Blue Shield and other insurance carriers to be made directly to the provider. I certify that the information I have reported with regard to my insurance carrier is correct. I authorize the release of medical information about me or a family member to my health insurance carrier(s), and any and all other information to determine the benefits payable for related services.

Signature of Patient, Parent, or Legal Guardian _____ Date _____

Print Name of Patient, Parent, or Legal Guardian _____ Date _____

FINANCIAL POLICY

If medical insurance is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable to Ruth & Norman Rales Jewish Family Services. When participating with an insurance carrier, services that are not fully reimbursed by your insurance and are indicated by your insurance's Explanation of Benefits to be the patient's responsibility will be due and payable upon receipt of a billing statement. Unless you are covered by a government program (Medicare), or a private insurance that has an agreement that prohibits members from being billed, and if correct insurance information or referral documentation is not presented at the time of service, you are responsible for the full charges incurred.

I further understand that information communicated to the insurance carrier may be through electronic transmission, written, oral, or by fax. A photocopy of this assignment is to be considered as a valid original. Information released is strictly for treatment, payment, or healthcare operations allowed by law under HIPAA and Florida State regulations.

This assignment of benefit will remain in effect until revoked by me in writing.

Signature of Patient, Parent, or Legal Guardian _____ Date _____

Print Name of Patient, Parent, or Legal Guardian _____ Date _____

Form accepted and reviewed by (name): _____ Date: _____