The Grove
COUNSELING CENTER, INC.

CONSENT FORM

Client Name: _____

_____ **Consent for Treatment**
I, the undersigned, authorize The Grove Counseling Center, Inc. (The Grove) to provide substance abuse services consistent with the level of my needs per assessment. I certify that I fully understand the treatment process as explained to me. I have been made aware of the purpose and structure of the program to which I am being admitted and the expected length of time in treatment.

_____ **Acknowledgement of Client Rights**
I, the undersigned, acknowledge that I have received a copy of my rights as a client with The Grove and that a staff member of The Grove has reviewed these rights with me.

_____ **Acknowledgement of Privacy Notice**
I, the undersigned, acknowledge that I have received a copy of The Grove's Privacy Notice that explains how protected health information about me may be used and disclosed and how I can get access to this information.

_____ **Consent for Urinalysis**
I, the undersigned, consent to provide urine samples for analysis whenever requested by The Grove. I understand that urinalysis may be used to evaluate my need for treatment and/or monitor my progress in treatment. I understand that visual observation of urine collection by staff may be necessary and, if conducted, will be done by a person of the same gender as the client. I understand that urinalysis results are confidential except as I have given consent for the release of this information or as legally required.

___ **Acknowledgement of Abuse Reporting Requirements**
I, the undersigned, acknowledge that according to Florida Statutes 39.201 and 415, any abuse or neglect perpetrated by a caretaker and revealed to The Grove staff during the course of intake, assessment, and treatment will require that a verbal and/or written report be submitted to the Florida Department of Children and Families Abuse Registry. The Grove is not responsible for determining the validity of the report.

_____ **Acknowledgement for Reporting of Communicable Diseases**
In accordance with Florida Statutes 381.0031 and 384.25, I, the undersigned, acknowledge that the Medical Director, or designee, may be required to report any communicable disease I may have, or be suspected of having, that may pose a significant threat to the general public during the course of my treatment with The Grove.

_____ **Consent for Search and Seizure**
I, the undersigned, understand that there are times The Grove staff may need to conduct searches of my possessions or person in order to maintain the security and safety of the facility.

_____ **Consent for Photography**
I, the undersigned, consent to any photos of me.

I have read and fully understand this consent form and the fact that it expires 365 days from my signature.

_____	_____
Client Signature	Date
_____	_____
Parent / Guardian Signature	Date
_____	_____
itness Signature	Date

The Grove
COUNSELING CENTER, INC.

MEDICAL RELEASE/CONSENT FOR TREATMENT

I understand that while my child or ward _____

Is in treatment at The Grove Counseling Center, Inc., I will be responsible for all medical problems that occur. I give The Grove Staff permission to draw blood and collect urine for laboratory test, administer routine treatment for minor medical problems such as minor cuts, abrasions, fever, nausea, etc., and to render first aid in medical emergencies.

I authorize The Grove and/or its' agents to transport my child or ward to the nearest emergency facility and I agree to be responsible for all cost of transportation and treatment. For other medical treatment, I will be responsible for scheduling transportation, payment, and obtaining prescribed treatment and/or medication.

_____ _____
Parent or Guardian Date

_____ _____
Witness Date

Revised: March 10, 2014

The Grove
COUNSELING CENTER, INC.

CLIENT VITAL STATISTICS

EMERGENCY INFORMATION FORM

DATE OF ADMISSION: _____ CLIENT SISAR #: _____

CLIENT NAME: _____
LAST FIRST MIDDLE

SOCIAL SECURITY NO: _____ CITY & STATE OF BIRTH: _____

Name of Insurance/RX: _____ MEDICAID# _____
(Copy of card for client file/Nurse Station)

DATE OF BIRTH: _____ AGE: _____ SEX: _____ RACE: _____ HEIGHT: _____

WEIGHT: _____ COLOR OF HAIR: _____ COLOR OF EYES: _____

ANY DISTINGUISHING MARK(S): _____

MEDICAL PROBLEMS OR ALLERGIES: _____

CURRENT GRADE LEVEL: _____ Year Graduated _____ GED: YES/NO

LAST SCHOOL ATTENDED: _____ COUNTY: _____

MOTHER'S NAME: _____

)DRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

HOME PHONE #: _____ WORK OR CELL PHONE _____

FATHER'S NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK OR CELL PHONE: _____

EMAIL: _____

NAME OF LEGAL GUARDIAN(S): _____ CONTACT #: _____

CASE MANAGER: _____ WORK PHONE #: _____

CELL PHONE: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CM FAX #: _____ LEGAL STATUS: _____

?OBATION OFFICER: _____ WORK PHONE# _____

INTAKE PERSON: _____

Revised: March 10, 2014

The Grove
COUNSELING CENTER, INC.

Client Name: _____ **Date:** _____

APPROVED VISITATION LIST

Person must show a valid picture ID to visit!

Name of person approved	Relationship to client

APPROVED PHONE CONTACT LIST

Name of person approved	Relationship to client	Phone Number

APPROVED MAILING LIST

Name of person approved and Address	Relationship to client

Parent Signature: _____

Revised: December 19, 2013

The Grove
COUNSELING CENTER, INC.

Permission for Required Immunizations,

Vaccinations, And Mantoux (TB) Test

Client Name: _____

I hereby authorize The Grove Counseling Center, Inc., Adolescent Residential Program, to administer by The Grove staff nurse or transport the above named client to the Seminole County Health Department, Sanford, Florida, to receive required immunizations, vaccinations, and the Mantoux test for TB for enrollment in the Florida Virtual School Program. This is to ensure compliance with state regulations in order to enroll the client into the Florida Virtual School. If you do not have proof of TB vaccinations with you our facility will give the TB shot the fee is $12.00.

_____ _____

Parent / Guardian Signature **Date**

Permission for Release of Results Mantoux (TB) Test

I, _____ give permission for the release of my TB results to The Grove Academy Adolescent Residential Program.

My test was taken at _____ on/or around the date of
Test location

_____.
Test Date

_____ _____

Client Signature **Date**

Revised: March 10, 2014

The Grove
COUNSELING CENTER, INC.

Qualifying Companies for Services

Client Name: _____

The Grove Counseling Center, Inc., The Academy utilizes Quest Diagnostics for Lab work and Colonial Drugs for Prescription medications at our facility. If for some reason your medical insurance does not accept/use Quest Diagnostics or Colonial Drugs and will not cover costs associated with them please list below the qualifying companies your medical insurance uses.

Lab work (i.e. blood work, urinalysis, etc.):

_____

_____

Prescription Medications:

_____

_____

If the above listing is blank then The Grove Counseling Center, Inc., The Academy, will presume your insurance company does accept/use Quest Diagnostics and Colonial Drugs. If any ancillary services are rendered and not paid by your insurance carrier the parent/guardian will held financially responsible.

_____ _____

Parent/Guardian Date

_____ _____

Witness Date

Revised: December 19, 2013

The Grove
COUNSELING CENTER, INC.

PRN MEDICATIONS/ STANDING ORDERS

Client Name: _____ Admit Date: _____

Approved	Declined	Symptoms	Medication Given
		Upset Stomach Diarrhea Heartburn Indigestion Nausea	Bismuth Subsalicylate 262 mg (Pepto-Bismal) Swallow (do not chew) 2 tablets by mouth with water every ½ - 1 hour as needed for upset stomach, diarrhea, heartburn, indigestion, or nausea until symptoms relieved Maximum 16 chewable tablets in 24 hours, but not more than 2 consecutive days. Tums – 2 chewable tablets after meals as needed for indigestion
		Menstrual Cramps	Ibuprofen 200 mg tabs (Advil) 2 tablets (400 mg) by mouth every 4 hours as needed for menstrual cramps Maximum 8 tablets (1600 mg) in 24 hours
		Muscle Pain	Ibuprofen 200 mg tabs (Advil) 2 tablets (400 mg) by mouth every 4 hours as needed for muscle pain Maximum 8 tablets (1600 mg) in 24 hours
		Headache	Acetaminophen 325 mg tabs (Tylenol) 2 tablets (650 mg) by mouth every 6 hours as needed for headache Maximum 6 tablets (1950 mg) in 24 hours
		Nasal Congestion	Pseudoephedrine 30 mg tabs (Sudafed) 2 tablets (60 mg) by mouth every 6 hours as needed for nasal congestion Maximum 6 tablets (180 mg) in 24 hours
		Sore Throat	½ teaspoon of salt dissolved in 8 ounces of water Gargle for 10 – 15 seconds. Repeat every hour as needed for throat pain.
		Fever 101° or higher	Acetaminophen 325 mg tabs (Tylenol) 2 tablets by mouth for fever 101° or higher Take temperature one hour after administration of medication Maximum 6 tablets (1950 mg) in 24 hours CALL NURSE TO REPORT CLIENT'S TEMPERATURE BEFORE ADMINISTRATION AND CALL NURSE ONE HOUR AFTER ADMINISTRATION TO REPORT TEMPERATURE
		Allergic Reaction	Diphenhydramine 25 mg caps (Benadryl) 1 capsule (25 mg) by mouth every four hours for allergic reaction Maximum 4 caps (100 mg) in 24 hours CALL NURSE BEFORE ADMINISTRATION
		Cuts / Abrasions	Cleanse with soap and water. Apply antibiotic ointment. Apply bandage only if bleeding or exudate.
		Skin Irritation/Rash	Hydrocortisone / Anti-Itch Cream 0.5% cream Apply to affected area every 2 hours as needed for itching. Calamine lotion – apply to affected area as needed for rash/itching
		Cough	Guaifenesin non–alcohol syrup: 1 tablespoon as needed for cough every 4-6 hours
		Insomnia	Melatonin 5 mg PO tablets. One tablet by mouth at bedtime as needed for insomnia

NURSE: 407-327-1765

zi Ahmad, MD

_____
Parent/Guardian

Revised: March 11, 2014

The Grove
COUNSELING CENTER, INC.

STANDING MEDICAL ORDERS

LIST OF MEDICATIONS PRESENTLY TAKING

Client Name: _____ **Date:** _____

MEDICATION: _____

DOSAGE: _____

DURATION: _____

FREQUENCY: _____

AMOUNT: _____

SPECIAL INSTRUCTIONS: _____

_____

MEDICATION: _____

DOSAGE: _____

DURATION: _____

FREQUENCY: _____

1OUNT: _____

SPECIAL INSTRUCTIONS: _____

_____

MEDICATION: _____

DOSAGE: _____

DURATION: _____

FREQUENCY: _____

AMOUNT: _____

SPECIAL INSTRUCTIONS: _____

_____

_____ _____

MEDICAL DIRECTOR **DATE**

_____ _____

RENT/GUARDIAN **DATE**

Revised: March 10, 2014

The Grove
COUNSELING CENTER, INC.

I, _____ understand that if my child causes any damages to the
Parent/Guardian

fixtures, furnishings, drywall, staff/grove vehicles or anything else on The Grove Counseling Center, Inc., Grove Academy property that I, _____ will be
Parent/Guardian

required to pay for the cost to repair any/all of these damages as well as the labor to repair them. Should these circumstances arise, The Grove Counseling Center, Inc. will complete the repairs and submit a bill to you for this payment in full.

_____ _____
Parent/Guardian Signature *Date*

_____ _____
Witness signature/printed name *Date*

The Grove
COUNSELING CENTER, INC.

Educational Agreement

Client Name _____

Virtual School web site: **www.flvs.net**

New Student:

_____ I have agreed to enroll my child in the Florida Virtual School program.

_____ I understand to receive school credits my child must complete the course in its entirety. Any unfinished work will result in zero school transfer credits.

_____ The following has been explained to me and I understand that I must complete the following steps to ensure my child's transition into virtual school: Once the approval letter is received from school board (which comes by mail or e-mail), the letter must be faxed to the virtual school number provided to you on intake. Failure to do this will result in a delay in your child beginning courses through the virtual school program.

Existing Student:

_____ I agree to allow my child to continue enrollment in the Virtual School program

_____ I understand that I must provide the user name and password to my child's therapist to monitor my child's progress.

Students User Name _____ Password _____

Parents User Name _____ Password _____

OTHER:

_____ If your child has already obtained his/her GED or high school diploma, your child may still attend the classroom and obtain the knowledge and educational piece for college courses; however, transfer credits are not earned.

_____ _____
Parent/Guardian signature Date

_____ _____
Witness Signature Date

Revised: March 10, 2014

The Grove Academy
Student Information Sheet

To be filled out by the parent or registrar

Name:	Legal Guardian:
DOB: / / Age: Grade:	Type: Mother ☐ Father ☐ Other ☐
S.S. #: - -	Phone #: ( )
Last School Attended	Address:
County:	
Email:	Email:

To be filled out by the teacher

Login ID:	Login ID:
PW:	PW:
Security Question 1:	Answer:
Security Question 2:	Answer:

Special Notes: Date Enrolled in FLVS: / / Transcripts Requested: yes ☐ no ☐

Course:	Teacher:
Segment 1 ☐ Segment 2 ☐	Email:
Date Course approved: / /	Phone #:

Course:	Teacher:
Segment 1 ☐ Segment 2 ☐	Email:
Date Course approved: / /	Phone #:

Notes

The Grove
COUNSELING CENTER, INC.

INITIAL TREATMENT PLAN (Residential)

Client Name: _____ ID #: _____ Date of Admission: _____

Provisional ICD-9 Diagnosis & GAF:

Primary: _____ GAF: _____

Medical Services			Behavioral Health Services		
Service	**Frequency**	**Due Date**	**Service**	**Frequency**	**Due Date**
HIV/AIDS & TB Risk Assessment	X 1	At Intake	Admission ASAM	X 1	Upon Admission
Basic Blood Tests (if needed)	X 1	Upon Admission	Initial Treatment Plan	X 1	Within 24 hours
Serological STD Test (RPR)	X 1	Upon Admission	Biopsychosocial Evaluation	X 1	Within 10 days
Confirmation of last TB test	X 1	Upon Admission	Treatment Plan Development	X 1	Within 15 days
Urinalysis	X 1	Upon Admission	Individual Counseling	Weekly	Over next 30 days
Medical History	X 1	Within 24 hours	Group Counseling	Daily	Over next 30 days
Physical Examination	X 1	Within 10 days	Family Counseling	As scheduled	Over next 30 days
Infection Control Education	X 1	Within 24 hours	Client Orientation	X 1	Upon Admission
If pregnant female: Refer for prenatal care	X 1	Within 10 days	Other:		
Other:			Other:		

GOAL: To ensure stabilization of client, appropriateness for current level of treatment, and assessment of current medical / behavioral health needs.		
Objective		**Target Date**
Objective #1:	The client will participate in a comprehensive psychosocial assessment to determine treatment goals to aid in the development of an Individualized Treatment Plan.	Within 30 days
Objective #2:	To assess the client's health status and determine necessary medical interventions.	Within 10 days
Objective #3:	To assess the client's educational status and develop an educational plan.	Within 30 days
Objective #4:		
Objective #5:		

SIGNATURES & AUTHORIZATIONS*

I agree to pursue the goal and objectives on this Initial Treatment Plan and to cooperate with staff in completing assessments to determine goals and objectives for the development of an Individualized Treatment Plan. This Initial Treatment Plan has been reviewed with me.

_____ _____
Parent Signature Date

_____ _____
Client Signature Date

_____ _____
Counselor Signature Date

*This plan remains in effect for 30 days from the above signature date or until an Individualized Treatment Plan is developed.

Revised: March 10, 2014

The Grove
COUNSELING CENTER, INC.

CONFIDENTIALITY AGREEMENT

Client Name: _____

I hereby acknowledge that I understand The Grove's commitment to safeguard the identity of all clients, the confidentiality of all records, and the communications between staff members and the service receiver.

Therefore, I agree not to reveal to any person outside of this facility the name of any client or any of the information listed below:

1. The identity of any client, whether in the past, present or future.
2. Any information concerning the contents of client records.

In addition, I agree not to reveal any information that could:

1. Lead anyone to learn the identity of any person who is, has been, or may become a client of The Grove.
2. Lead anyone to learn the identity, or contents of the records of statistical information kept by The Grove regarding clients.

I understand that my violation of this agreement could make me liable for monetary damages.

I have read the above information and agree to adhere to, and abide by it.

Client Signature	Date
Parent / Guardian Signature	Date
Witness Signature	Date

Revised: March 10, 2014

The Grove
COUNSELING CENTER, INC.

CONSENT FOR FOLLOW-UP

Client Name: _____

_____ I give permission for a representative of The Grove Counseling Center, Inc. to contact me for purposes of obtaining follow-up information regarding my status and progress on treatment-related issues after being discharged from treatment services. I understand that the time at which I will be contacted is predetermined based on the program in which I participated and that follow-up measurements may need to be taken at more than one time interval, but at no point would exceed one year past my discharge date.

I can be contacted at:

Street or PO Box _____
City, State, Zip Code _____
Telephone Number _____

I understand that if I give consent for follow-up, contact will attempt to be made via telephone unless I expressly request that I be contacted via an alternative method (e.g. mail).

If the representative is unable to contact me for follow-up, I authorize the person(s) below to provide an alternative method for contacting me or to provide answers regarding my status and progress for the follow-up survey to the best of their knowledge.

Contact Person _____
Relationship to Client _____
Street or PO Box _____
City, State, Zip Code _____
Telephone Number _____

I understand that this consent will expire 365 days post-discharge from treatment services with The Grove unless it has been revoked by me in writing prior to that date.

_____ ***I do not give consent for follow-up contact.***

I have read and fully understand this consent form and acknowledge that I have received a copy.

_____ _____
Client Signature Date

_____ _____
Parent / Guardian Signature Date

_____ _____
Witness Signature Date

Revised: March 10, 2014

The Grove
COUNSELING CENTER, INC.

SICK CALL PROCEDURE

Client Name: _____ **Date:** _____

1. **In the morning if you are feeling ill, you must get out of bed and report your illness to the staff.**
2. **The BMT will place you on the sick-call list in the nurse's station (No later than 10:00 AM.).**
3. **All bed rest must be approved PRIOR to taking bed rest, with the exception of a temperature.**
4. **Clients must do their morning chore, unless they have a temperature.**
5. **If the client has a temperature or is approved by the nurse for bed rest, the dorm chief will assign their chore to someone else for the day.**
6. **Clients placed on bed rest will have soup for the remainder of the day, unless the nurse has authorized a regular meal.**
7. **Clients on bed rest must remain IN BED until the next day.**
8. **Clients on bed rest will lose phone privileges for that day, and time/call may not be made up.**
9. **Clients on bed rest will take last shower.**
10. **If a client is on bed rest and has been assigned to do laundry that day, they are permitted to do laundry.**
11. **If you are on bed rest, you will miss ALL ACTIVITIES until you are off bed rest.**
12. **If you get up out of bed, other than going to the rest room, you will lose points for that day and still miss the ACTIVITIES for that day.**

_____ _____

Client Signature **Parent/Guardian Signature**

The Grove
COUNSELING CENTER, INC.

Responsibility of Personal Property

I, _____ and _____ understand that any
Parent/Guardian Client Name

property that the client brings to The Grove Counseling Center, Inc. will not be held for more than thirty (30) days from the clients date of discharge. This includes any type of discharge, whether voluntary or involuntary. Any items that are here after the thirty (30) days will be destroyed and The Grove Counseling Center, Inc. will not be held responsible.

Any property of mine that is expensive or I do not want damaged, if applicable, should not be brought to the facility at any time. If it is, The Grove will not be responsible for any damages done to these items nor reimburse me for the cost to replace these items.

In addition any item that is listed as contraband and is confiscated upon returning from any offsite activity or home/meal pass will not be the responsibility of The Grove Counseling Center, Inc. at any time. Please have the client remove any of these items prior to returning; this includes jewelry, wallets, money, etc. There is a complete list of contraband items in the handbook that has been provided to me.

_____ _____
Parent/Guardian Signature Date

_____ _____
Client Signature Date

_____ _____
Witness Date

The Grove
COUNSELING CENTER, INC.

CLIENT ORIENTATION

Client Name: _____

I, the undersigned, acknowledge that I have received a full orientation to the program in which I am receiving services. This orientation has included at least the following information:

_____ My rights and responsibilities and what the program expects from me as a client

_____ The purpose and process of assessment

_____ How my individual plan for treatment will be developed with input from me and others as appropriate (guardian, PO, etc.)

_____ The criteria and process for transitioning to aftercare services

_____ A copy of the program's rules including any restrictions or loss of rights and privileges; events, behaviors, and attitudes that may lead to the loss of rights and privileges; and means by which loss of such rights and privileges may be regained

_____ How to file a grievance and the grievance procedure

_____ Methods of obtaining input to evaluate the quality of care, achievement of outcomes and client satisfaction

_____ An explanation of the program's services and activities including identification of any therapeutic methods such as sanctions, interventions, incentives, or administrative discharge criteria and any expectations for consistent court appearances, if applicable

_____ Hours of program operation and access to after-hour services

___ The agency's code of ethics, confidentiality policy, and privacy notice

_____ An explanation of any financial obligations, fees or other financial arrangements as payment for services received

_____ An explanation of the emergency exit plan and access to fire suppression equipment and first aid kits

_____ Identification of key staff and their roles and the person responsible for service coordination

_____ Youth caught possessing tobacco products or tobacco paraphilia (lighters, matches etc.) will have to attend the Tobacco 411 class. The cost of the Tobacco 411 class is $30.00 and is not covered by the residential fee (Smoking Statute Handout).

_____ An explanation of the agency's policies regarding:
1. Bringing legal or illegal drugs onto Grove property.
2. Bringing weapons onto Grove property.
3. Infection control.
4. Sick Call Procedure.

_____ _____
Client Signature Date

_____ _____
Parent / Guardian Signature Date

_____ _____
Witness Signature Date

CHAPS
CENTER FOR HORSEMANSHIP AND PERSONAL SUCCESS

STABLE FOUNDATIONS
Equine Assisted Family Therapy

STABLE FOUNDATIONS

Lorisa P. Lewis, MS, LMHC, LLC
2441 W. SR 426, Suite 1021
Oviedo, FL 32765
407-493-9656

CONSENT FOR THE TREATMENT OF MINORS

NAME OF CLIENT:_____

Client Date of Birth: _____ **Current Age:**_____ **Current Grade:** _____

This is to certify that I give permission to STABLE FOUNDATIONS in association with CHAPS, Inc. to treat my minor child. This treatment may include individual or group psychotherapy, counseling , evaluation and equine assisted learning services. This treatment may include consultations with other associates of this program and may include referrals to other appropriate State and County or professional agencies for further services.

By signing this document, I further attest that I am the legal parent/guardian of the above named child and have full legal right and ability, without restriction, to provide such consent for treatment.

_____ _____
Signature of Parent/Guardian **Date**

_____
Printed Name of Parent/Guardian

_____
Street Address

_____
City/State/Zip

_____
Phone (home and cell)