MENTAL HEALTH ASSOCIATION
IN INDIAN RIVER COUNTY

Mental Health Association in Indian River County:
Psycho-educational Class Registration Form (Adult)

Your Name: ______________________________ Date: ___________
(Last) (First) (Middle Initial)

How did you hear about us?
☐ 211 ☐ Behavioral Health Center ☐ Childcare Resources ☐ CORE/Probation ☐ Clerk of the Court
☐ DCF ☐ Doctor:__________________ ☐ Family ☐ Friend ☐ Health Department ☐ Healthy Start
☐ Hospital/Emergency Room ☐ Print Ad ☐ Radio ☐ Return Client ☐ School ☐ Self
☐ Victims Advocacy ☐ Vocational Rehabilitation ☐ Website ☐ Other:______________________

Your Gender: __________________ Your DOB: ____________ Your Age: _________
Your Address: ____
(Street) (Apt.) (City) (Zip code)

County: ☐ Indian River ☐ St. Lucie ☐ Martin ☐ Brevard ☐ Other: ____________________
Home phone: ______________________________ Cell phone: ______________________________
Work phone: ________________________ Email: ____
Preferred contact: ☐ Home # ☐ Cell # ☐ Work # ☐ Email Can we leave a message? ☐ Yes ☐ No

Emergency contact name: ________________________________ Phone: ________________________
Relationship of emergency contact to me: ____

Highest Grade/Education completed: __________________Race/Ethnicity: ________________________
Marital status: ☐ Married ☐ Single ☐ Living with committed partner ☐ Divorced ☐ Separated ☐ Widowed
Estimated Gross Annual Household Income: __________________ Occupation: _____________________
Do you have health insurance coverage? ☐ Yes ☐ No Name: ____________________________________
Are you a veteran? ☐ Yes ☐ No Are you a US citizen? ☐ Yes ☐ No
Who lives with you? ______________________________ Ages of children in home: ________________
Briefly describe reason you are interested in class services: ________________________________
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NOTE: Psycho-educational classes are not therapy services, but educational intervention for skill building. Your signature on this form indicates you acknowledge understanding of this.

Your Signature:		Date:	

Mental Health Association in Indian River County: Consent for Group Enrollment (Adult)

Client Name: ______________________________________ DOB: _____________

Chart #: ______________ Date: _____________

Consent to Evaluate/Treat: I voluntarily consent to participate in an initial mental health screening, evaluation and/or treatment by staff from the Mental Health Association in Indian River County. Screening, evaluation and/or treatment services are conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment is conducted within the boundaries of Florida Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family therapy.

Acknowledgement of Notice of Information Practices: I have received the Notice of Information Practices and Federal Privacy Standards of the Mental Health Association in Indian River County. I am aware should I have a grievance with the Mental Health Association in Indian River County: 1) I may file a grievance compliant form or a breach of Protected Health Information (PHI) grievance form; 2) I will not be retaliated against by MHA for filing a grievance; 3) continued services by MHA will not be affected by filing a grievance. If I have any questions about this notice, I may contact the MHA Privacy Officer, Angela Guzenski, (772) 569-9788, ext. 26. I may also file a complaint with the Department of Health and Human Services at 1-877-696-6775 (HHS Hotline).

Benefits/Risks to Treatment: I understand there may be both risks and benefits associated with participation in mental health services. Treatment may provide a clearer understanding of needs, self, values, and goals; facilitate the ability to relate to others; enhance academic or work performance; improve relationships with self and others; and/or expand ability to deal with everyday stress. Although services can be beneficial to many people, it may not be helpful for everyone. I understand it is my responsibility to actively participate in treatment. There may be some risks in participating in mental health services including, but are not limited to: addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; or being inconvenienced due to costs or scheduling of services. I am aware I can discuss any unforeseen risks versus benefits with my mental health provider at any time.

Alternatives to Treatment: The use of alternative approaches to mental health care can be substantially helpful to people living with mental health issues. Complementary or alternative approaches to mental health care include self-help, diet and nutrition, expressive therapies, acupuncture, yoga, and relaxation and stress reduction techniques.

Possible consequences of not participating in treatment: Consequences of not participating in treatment can include: continuation or worsening of mental health symptoms or conditions; continuation or development of issues that negatively affect daily functioning; and continuation or worsening of relationships and interactions with others. Neglect of mental health treatment needs can lead to safety concerns.

Charges: Fees are based on the length or type of treatment that is provided. We have set fees for group services.

Confidentiality, Harm, and Inquiry: Information from the screening, evaluation and/or treatment is contained in a confidential medical record at the Mental Health Association in Indian River County. I consent to disclosure for use by the Mental Health Association in Indian River County staff for the purpose of continuity of my care. Per Florida mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse, neglect or exploitation of a minor, elderly or disabled person arise; 3) if a court order is issued to obtain my records; 4) if MHA has information in an emergency that is essential to my health and well-being; and 5) if I sign a release to disclose listed information to a named party.

Discharge from Care: We reserve the right to discharge from care anyone unable or unwilling to participate in treatment. Reasons to discharge for care include: 1) failing to attend scheduled services; 2) failing to meet your financial obligations for care; 3) receiving maximum benefit from services; or 4) successfully completing services.

Discontinuation of Initiated Services: We reserve the right to end an initiated service or stop providing care if the safety of individuals or the center environment is compromised, if services cannot be appropriately rendered due to the present circumstances, or for any reason deemed appropriate or necessary by the program, including but not limited to, the following. The person seeking services: 1) appears to be under the influence of drugs or alcohol; 2) is in possession of a weapon, drugs or alcohol; 3) is engaging in belligerent, confrontational or threatening behaviors and fails to engage in de-escalation or redirection; 4) appears to be too physically ill or medically unwell to participate in services appropriately; 5) refuses to pay for services or to comply with staff assistance to access funding options; or for 6) the need to close our offices due to weather or other unforeseen conditions.

Right to Withdraw Consent: I have the right to withdraw my consent for care services at any time verbally or by providing a written request to MHA.

My signature on this form indicates I have read and understand the above; had the opportunity to ask questions if needed about this information; consent to treatment; and was offered a copy of this form.

Client Signature:		**Date:**	

Witness Signature:		Date:	