RESTORATION COUNSELING
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# Client Information

Today's Date _____ Individual completing form _____

## Referral

How Did You Hear About Us?_____ May We Contact This Person To Thank Them: ☐ Yes ☐ No

If You Agree To Let Us Thank Them, Sign Here: _____ Date: _____

Referrals Phone Number: (_____)_____ Referrals Email Address:_____

## General Information

Full Name: _____ Name You Prefer _____ Gender _____

Social Security: _____Age: _____ Date of Birth: _____

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Cell Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Work Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes ☐ No

Preferred method to receive appointment reminders (check all desired): ☐ phone call ☐ text ☐ email

Client/guardian initials:_____

## Emergency

Contact Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

Address: _____

## Employment and Education

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Highest Education/Additional Training: _____

Currently in School: ☐ Yes ☐ No If Yes, What Level: _____ Degree Pursuing: _____

☐ 504 Plan ☐ Special Education/IEP:_____ Past / Present truancy : ☐ Yes ☐ No

Suspensions ☐ Yes ☐ No Reason and date _____

Expulsions ☐ Yes ☐ No Reason and date _____

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**Relational Information**

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No If No, Briefly Explain: _____

If Married, Separated, Divorced, or Widowed, How Long: _____Number of Previous Marriages for You: _____Your Partner: _____

Partner's Name: _____Age: _____ Preferred Name: _____

Partner's Occupation: _____ Average Hours Worked Per Week: _____ What

Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (Check All that Apply): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate(s) ☐ Other: _____

**Children** - Please list your children and describe your relationship

| Name | Gender | Age | Bio/Adopted/Step | Residence | Describe your connection |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Other Family** - Please list other family relationships that have impacted your life (parents, siblings, others)

| Name | Gender | Age | Bio/Adopted/Step | Residence | Describe your connection |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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**Insurance information** Are you the policy holder? ☐ Yes ☐ No (if no, complete next 4 lines)

Policy holder name: _____ Policy holder DOB: _____

Policy holder address: _____ Policy holder phone: _____

Insurance company name: _____ Policy number: _____

Group number: _____

**Legal History**

Is the client currently engaged in legal process (custody, etc.)? ☐ Yes ☐ No If yes, please explain: _____

Has the client been charged with a crime? ☐ Yes ☐ No If yes, please explain: _____

Is the client on probation? ☐ Yes ☐ No If yes, please explain: _____

Is treatment court-ordered? ☐ Yes ☐ No If yes, please explain: _____

**Substance Use History**

☐ None ☐ Tobacco ☐ Alcohol ☐ Other substance _____

Attended alcohol/drug abuse treatment: ☐Yes ☐No

Has the client been told that they have an alcohol/drug problem: ☐Yes ☐NA

Gambling/Pornography/Internet Issues: _____

**Mental Health History/Hospitalizations**: ☐ No previous therapy ☐ Outpatient Treatment

Type of treatment: (Circle all that apply) Individual therapy Family therapy Group therapy

Provider: _____

Dates/Reasons for treatment/Response to treatment: _____

_____

_____

Previously hospitalized: ☐ Yes ☐ No ☐ N/A Multiple Hospitalizations: ☐ Yes _____

Last psychiatric facility _____ Date Admitted _____Date Dismissed_____

**General Medical/Health/Nutritional Issues/Current Medications**:

_____

_____

_____

History of hospitalization due to a medical condition: ☐ Yes ☐ No If yes, please describe _____

Medication Allergies/Response _____ Food Allergies/Response _____

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**Client Name:** _____ **Client DOB:** _____

**Primary Care Physician (PCP):** In Kansas, licensed mental health professionals are required to consult with a PCP or psychiatrist whenever symptoms of a mental health diagnosis are present. The purpose of consultation is to determine if there may be a medical condition/medication that may be causing/contributing to symptoms. The client/parent/legal guardian may also choose to waive such consultation. The clinician may provide treatment or evaluation until such time that the medical consultation is obtained/waived.

PCP NAME:_____ PHONE:_____

PRACTICE/ADDRESS:_____

Visit/Checkup with PCP within the past 12 months: ☐ Yes ☐ No Regular preventative health screens: ☐ Yes ☐ No

Consent to consultation with PCP regarding Mental Health Diagnosis and/or medication: ☐ Yes ☐ No - declined

Client/guardian initials:_____

**Medication Consultation**: In addition, the most effective treatment for mood disorders includes a combination of prescription medication and psychotherapy. All persons with these diagnoses are strongly recommended to seek medical advice from their PCP, a Medication Clinic, or other medical professional.

NAME:_____ PHONE:_____

ADDRESS:_____

Has the client been consistently taking these medications as prescribed ☐Yes ☐No

Consent for consultation with medication provider (dx/evaluation/referral): ☐Yes ☐No

Client/guardian initials:_____

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## Client Bill of Rights

1. You have the right to choose when to begin and when to terminate therapy.

2. You have the right to request a referral to another therapist or agency.

3. You have the right to receive information regarding fees for services and "late cancel" and "no-show" fees. (see financial agreement)

4. You have the right to receive respectful treatment in a safe environment free from sexual, physical, and emotional abuse or illegal behaviors. You have the right to have your cultural, spiritual, and personal values respected.

5. You have the right to request information regarding your therapist's qualifications, licensure, education, training, experience, and limits of practice.

6. You have the right to share only the information that you wish to disclose.
    a. Your signed informed consent must be given before audio or video recording.
    b. Your therapist may consult with the other clinicians regarding details of your treatment as a normal part of best practice, but none of your identifying information will be revealed without your written consent.
    c. If you are court-ordered to be evaluated or to attend therapy, there may be legal consequences for your refusal to cooperate and insurance may not cover the cost of "court-ordered" counseling.

7. You have the right to know your diagnosis, your treatment goals, and your progress if you request that information from your therapist.

8. You have the right to keep what you tell your therapist private and confidential unless you give permission to share the information with others. However, there are some situations in which your therapist is required by law to report with or without your permission, such as:
    a. If you threaten to hurt another person, your therapist must warn that person and the authorities.
    b. If there is physical or sexual abuse to a minor or disabled individual, your therapist must report it to the proper authorities.
    c. If you are suicidal or at risk of hurting yourself, your therapist must report to the police department or emergency contact so they can check on you.
    d. If your therapist receives a court order subpoenaing case records or testimony.

9. You may review your therapist's code of ethics and request a copy. We encourage you to report any concerns to your therapist or the office manager,

Client/Guardian Signature _____ Date _____

**Acknowledgment of Receipt of Privacy Notice**: I acknowledge that I have received a copy of the Notice of Privacy Practices of Restoration Counseling and Consultation, P.A. with the effective date of February 15, 2019.

Client/guardian initials:_____

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## Consent to Treat a Minor

Parents/guardians must provide legal consent before children/adolescents can receive counseling/psychotherapy services. This form is intended to secure legal consent from the client's parent/guardian before receiving treatment.

Names and date of birth of child(ren) to receive counseling/psychotherapy services:

Name of Child: _____ Date of Birth:_____

Name of Child: _____ Date of Birth:_____

Name of Child: _____ Date of Birth:_____

Name of Child: _____ Date of Birth:_____

Name of person requesting services: _____ Today's Date: _____

Your relationship to child: ☐ Parent ☐ Step-Parent ☐ Guardian ☐ Grandparent ☐ Other _____

Are you the parent or guardian to above-named children with legal authority to give consent? ☐ Yes ☐ No

In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above children.

Are you willing to do so? ☐ Yes ☐ No

If the answer to any of the above questions is "No," counseling/psychotherapy services cannot be provided to the above named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.

I, _____, consent to treatment of psychological services to the child(ren) named above. I acknowledge that both natural parents, even though divorced, may have a right to obtain from the therapist information regarding the nature and course of treatment of the child(ren).

Kansas State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

Parent/Guardian Signature _____ Date _____

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# Financial Agreement for Services

Our fees are based on the amount of time you are with your therapist. You are responsible for any fees not covered by insurance. By signing this agreement you agree to and acknowledge each of the following conditions.

- **Demographic updates**: you are responsible for notifying Restoration Counseling and Consultation, P.A. (RCC) of any changes in name, address, telephone number or insurance coverage.
- **Payment**: you, the client or client's parent or guardian, are responsible for payment of fees for professional services. Payment is **due** at the time of service.
- **Policies:** signing this form indicates that you have read the fee policy and accept full financial responsibility for this account, including any and all fees.
- **Insurance**: RCC will bill your insurance company, with written permission, for services rendered. You are responsible for completing any required preauthorization of services and for all applicable co-payments, deductibles, coinsurance, and non-allowable charges.
    - If your insurance company denies, refuses, or fails to make payments for the services rendered, you will be notified and asked to make payment of all charges due.
    - By signing this agreement, you agree to allow Restoration Counseling and Consultation, P.A. to release any and all mental health records necessary for filing insurance claims and collecting fees from your insurance company.
- **Fees**: Your first appointment (intake) requires more services and is billed at a higher rate of $185. Subsequent appointments are billed at $150 for 45-55 minute sessions.
    - **Additional services** (such as time spent beyond regular session, phone calls/after hours crises, court-ordered responses and appearances, reports) require additional charges and will be applied to your account.
- **Insufficient fund checks** will be assessed up to a $40.00 charge.
- You are expected to attend your scheduled appointments or cancel 24 hours prior. You will be charged a $40 fee for the first missed appointment and $100 for any subsequent missed appointment that was not cancelled at least 24 hours prior. Further missed appointments may result in termination of services and referral to another agency.
- **Cancellations**: Frequent cancellation of your appointments can be an indication of increased independence and diminished need for support. This is a good thing and may result in cancellation of your standing appointment in order to provide more support for others.
- **Non-payment** for services could result in termination of services. The collection agency will assess your costs of collection including related court, legal, and/or attorney fees. Services that have been terminated for non-payment will not be reopened without payment in full of all account balances.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment of insurance claims. I authorize payment of insurance benefits for service provided to be made directly to RCC. In the event that I am paid by my insurance company, I agree to promptly pay RCC.

My Signature confirms that I agree to this financial agreement.

Client/Guardian Signature _____ Date _____

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# RCC Telehealth Informed Consent

**Definitions:** Telehealth is the delivery of behavioral health services using interactive technologies (use of electronic communications) between a practitioner and a client/patient who are not in the same physical location. This service is provided by technology (**audio** by phone, **video** using the ***Therapy Appointment*** patient portal) and may not involve direct face to face communication. This delivery method offers **benefits** of convenience as well as **limitations** and **risks**.

1. All **previously signed agreements** and consent forms regarding treatment are **still in effect**. Clients have the **right** to withhold or withdraw their consent for telehealth treatment at any time without affecting their right to future care or treatment. In such cases, **clients have the right** to suspend treatment or request referral to another therapist.
2. The **interactive technologies** used in telehealth incorporate **security protocols** to protect the confidentiality of client/patient information transmitted via any electronic channel. Despite reasonable efforts to secure these systems, security breaches (exposing client protected health information) and equipment/service failures are still possible.
3. In order to participate in telehealth therapy, **clients will be responsible** for providing/ensuring:
    a. Access to appropriate **technology** and Internet service as well as familiarity with its function.
    b. **Security and functionality** for their own device and network.
    c. A **private space** free from distraction or intrusion/observation/listening of others.
4. Telehealth is a **new** delivery method for professional services, in an area not yet fully validated by research, and may have potential **risks**, possibly including some that are not yet recognized.
    a. An important part of traditional psychotherapy is sitting face to face with an individual, where non-verbal communication is readily available to both therapist and client. Without this information, telehealth therapy may be **slower** to progress or **less effective**. As with any treatment, there can be no guarantee that the client's condition will improve and in some cases the client's condition may worsen.
5. If a need for direct, **in-person services** arises, it is the **client's responsibility** to contact providers, such as the therapist's office for an in-person appointment or primary care physician if the therapist is unavailable. An opening may not be immediately available in either office and telehealth services cannot provide emergency care - it is the client's responsibility to call 911 in the case of an emergency.
6. The therapist and client will need to **regularly reassess** the appropriateness of continuing to deliver services through the use of the technologies agreed upon and modify the treatment plan as needed.
7. The **laws and professional standards** that apply to in-person behavioral health services also apply to telehealth services. As such, the information disclosed by the client during the course of therapy is confidential. However, there are mandatory **exceptions to confidentiality**, including, but not limited to (a) reporting child, elder, and dependent adult abuse; (b) expressed threats of violence towards an ascertainable victim; and (c) in the event that a court order exists compelling the therapist to reveal the client's protected health information.

**My signature below indicates that I understand and agree with the above terms and give my full and informed consent to receive telehealth psychotherapy/counseling services from a provider at Restoration Counseling & Consultation P.A.**

_____
Client Printed Name

_____ _____
Signature of Client or Legal Guardian Date

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# Your Information. Your Rights. Our Responsibilities.

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 Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

| | |
|---|---|
| **In these cases, you have both the right and choice to tell us to:** | • Share information with your family, close friends, or others involved in your care<br>• Share information in a disaster relief situation<br>• Include your information in a hospital directory<br>• Contact you for fundraising efforts<br>*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* |
| **In these cases we *never* share your information unless you give us written permission:** | • Marketing purposes<br>• Sale of your information<br>• Most sharing of psychotherapy notes |
| **In the case of fundraising:** | • We may contact you for fundraising efforts, but you can tell us not to contact you again. |

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

| | |
|---|---|
| **Get an electronic or paper copy of your medical record** | • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br>• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct your medical record** | • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We will say "yes" to all reasonable requests. |
| **Ask us to limit what we use or share** | • You can ask us **not** to use or share certain health information for treatment, payment, or our operations.<br>  • We are not required to agree to your request, and we may say "no" if it would affect your care.<br>• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.<br>  • We will say "yes" unless a law requires us to share that information. |
| **Get a list of those with whom we've shared information** | • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.<br>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| **Get a copy of this privacy notice** | • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| **Choose someone to act for you** | • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>• We will make sure the person has this authority and can act for you before we take any action. |
| **File a complaint if you feel your rights are violated** | • You can complain if you feel we have violated your rights by contacting us using the information on page 1.<br>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**<br>• We will not retaliate against you for filing a complaint. |

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

| | | |
|---|---|---|
| **Treat you** | • We can use your health information and share it with other professionals who are treating you. | *Example: A doctor treating you for an injury asks another doctor about your overall health condition.* |
| **Run our organization** | • We can use and share your health information to run our practice, improve your care, and contact you when necessary. | *Example: We use health information about you to manage your treatment and services.* |
| **Bill for your services** | • We can use and share your health information to bill and get payment from health plans or other entities. | *Example: We give information about you to your health insurance plan so it will pay for your services.* |

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

| | |
|---|---|
| **Help with public health and safety issues** | • We can share health information about you for certain situations such as:<br>  • Preventing disease<br>  • Helping with product recalls<br>  • Reporting adverse reactions to medications<br>  • Reporting suspected abuse, neglect, or domestic violence<br>  • Preventing or reducing a serious threat to anyone's health or safety |
| **Do research** | • We can use or share your information for health research. |
| **Comply with the law** | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |
| **Address workers' compensation, law enforcement, and other government requests** | • We can use or share health information about you:<br>  • For workers' compensation claims<br>  • For law enforcement purposes or with a law enforcement official<br>  • With health oversight agencies for activities authorized by law<br>  • For special government functions such as military, national security, and presidential protective services |
| **Respond to lawsuits and legal actions** | • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

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Notice Effective Date: February 15, 2019