Client Name: _____

Resolutions

Individual, Couple and Family Therapy

Therapist: _____

Date: _____

Primary Client Information

Name: _____ _____ _____ **Sex**: male female
First name Middle name Last name

Social Security Number: _____ **Date of Birth**: _____ **Drivers License #:** _____

Address: _____ _____ _____
Street address City State Zip Code

Home Phone: _____ **Cell Phone**: _____ **E-mail**: _____

**Calls or e-mails will be discreet, but please indicate any restrictions*: _____
Would you like a text or email reminder for your appointments? □ Yes, Text □ Yes, Email □ Neither

Employer: _____ **Occupation**: _____ **Work Phone**: _____

Employer Address: _____

Emergency Contact: _____ **Relationship**: _____ **Phone #**: _____

Additional Client Information (complete a second symptom checklist)

Name: _____ **Date of Birth**: _____ **Phone** : _____

Address: _____ **Relationship to Primary Client**: _____

Employer: _____ **Please list any other additional clients**: _____

Primary Insurance Information

Primary Insurance Company Name: _____ **Group #**: _____ **Policy #**: _____

Name of Policy Holder:_____ **Relationship to Client:** _____ **Sex**: male female

Social Security Number: _____ **Date of Birth**: _____ **Drivers License #:** _____

Policy Holder's Address: _____ **City/State**_____ **Zip Code:** _____

Home Phone: _____ **Cell Phone**: _____ **E-mail**: _____

**Calls or e-mails will be discreet, but please indicate any restrictions*: _____

Insured Employer: _____ **Occupation**: _____ **Work Phone**: _____

Secondary Insurance Information (If Applicable)

Secondary Insurance Company Name: _____ **Group #**: _____ **Policy #**: _____

Name of Policy Holder:_____ **Sex**: male female

Social Security Number: _____ **Date of Birth**: _____ **Drivers License #:** _____

Policy Holder's Address: _____ **City/State**_____ **Zip Code:** _____

Home Phone: _____ **Cell Phone**: _____ **E-mail**: _____

**Calls or e-mails will be discreet, but please indicate any restrictions*: _____

Insured Employer: _____ **Occupation**: _____ **Work Phone**: _____

Client Name: _____

Current Symptom Checklist (please rate the intensity of the symptoms and check all that apply.)

None = This symptom is not present at this time **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate = Significant impact on quality of life and / or day-to-day functioning **Severe** = Profound impact on quality of life and / or day-to-day functioning

Past = Have experienced this before but not within the past 6 months

Symptom	None	Mild	Moderate	Severe	Past	Symptom	None	Mild	Moderate	Severe	Past
Depressed Mood						Physically Aggressive					
Appetite Increase/Decrease						Defiance/Refusal					
Sleep Less/Too Much						School/Work Problems					
Fatigue / Low Energy						Social Awkwardness					
Feeling Slowed Down						Anxiety					
Lack of Enjoyment						Panic Attacks					
Emotionality						Phobias					
Tearfulness						Obsessions/Compulsions					
Sexual Dysfunction						Frequent headaches					
Poor Hygiene						Frequent stomachaches					
Grief						Muscle Tension					
Guilt						Constant Worry					
Hopelessness						Anorexia					
Worthlessness						Bingeing / Purging					
Social Isolation						Laxative / Diuretic Abuse					
Suicidal/Homicidal Thoughts						Constipation / Diarrhea					
Self-Harm						Hallucinations					
Mood Swings						Paranoia					
Elevated Mood						Emotional Trauma Victim					
Agitation						Physical Trauma Victim					
Racing Thoughts						Sexual Trauma Victim					
Hyperactivity						Emotional Trauma Perpetrator					
Poor Concentration						Physical Trauma Perpetrator					
Poor task completion						Sexual Trauma Perpetrator					
Impulsivity						Substance/Alcohol Abuse					
Easily Frustrated						Gambling					
Learning Disability						Relationship Conflict					
Developmental Disability						Infidelity					
Property Destruction						Other_____					

Please list current and/or past medical issues (including history of head injury, past surgeries, car accidents). _____

_____

Reason for seeking therapy: _____

Are you currently taking prescription medication? _____ yes _____ no If yes, please list below

_____

Medication Reason Dose How long?

_____

Medication Reason Dose How long?

Primary Care Physician:_____**Address:**_____**Phone #:**_____

How did you hear about us?_____

If you found us on the Internet, which search engine did you use? Google Bing Yahoo MSN

Client Name: _____

Resolutions

Individual, Couple and Family Therapy

Informed Consent and Therapy Contract

We feel it is important that, as our client, you are fully informed about the therapy services you will be receiving. Your signature below indicates you have received, read and understand the practice policies of this therapy site in helping you make an informed decision about entering therapy.

1. I understand my licensed therapist is a Licensed Marriage and Family Therapist or a Licensed Master Social Worker.

2. I understand my therapist is bound by the Code of Ethics set forth by the American Association for Marriage and Family Therapy (AAMFT) and by the National Association of Social Workers (NASW) and I can request a copy of those ethics at any time.

3. I understand, except under specific circumstances mandated by law, communication with my therapist will remain confidential, as will any records regarding the therapy process unless I sign a Release of Confidential Information form authorizing access to the information before any file information will be released in accordance with K.S.A. 65-6410. If more than one family member participates in a session, each participating family member must consent prior to the release of file information. Where a minor is receiving services, the appointment of a Guardian Ad Litem may be necessary prior to the release of the minor client's information. I understand my family members are not entitled access to my information just because they are family.

4. I understand, under Kansas law, specific circumstances require my therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when:
   a) The therapist believes the client is a danger to themselves or to others.
   b) The therapist believes that a child, elderly or disabled person may be subject to abuse or neglect.
   c) A court order exists that information regarding the therapy process be provided.

5. I understand, under Kansas law, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication contributing to symptoms of a mental disorder. To complete such a consultation, my therapist will request I complete a Release of Confidential Information form. I understand I may waive this consultation, in writing, and my therapist will discuss this process with me at any time if I so request.

6. I understand I may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session.

7. I understand the services provided are from Resolutions Individual, Couple and Family therapy, LLC (hereafter known as Resolutions) and my therapist is working as a contracted provider for Resolutions.

8. I understand the financial policies of Resolutions and I agree to pay the clinical hourly rate for all sessions attended. I understand I am responsible for all unpaid balances and / or denied claims by all third party payers. I understand if I am unable to attend a session I must call at least 24 hours in advance to cancel, otherwise the session will be billed at a regular session cost.

9. I understand there are third party billing and collection services that may be associated with information from my file in order to collect and / or make payment to my account and I give permission to share all necessary information with these services that may include, but are not limited to, insurance companies, collection agencies and office staff. I give permission for these groups to contact me on behalf of my therapist regarding any outstanding monies owed. Resolutions Therapy shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fee, and penalties and interest for the payment or nonpayment thereof.

10. I understand the therapists at Resolutions utilize the services of Therasoft, an online billing, collecting and file management system for records administration. I give permission for Resolutions to share all necessary data in the upkeep of my file with Therasoft. I understand all employees of Therasoft must abide by the same confidentiality and ethical rules as stated above.

11. I understand and grant permission for any necessary office staff, on-call therapist and / or any therapist at Resolutions to have access to my file for clerical and case management reasons. I understand all staff and therapists must abide by the same confidentiality and ethical rules as stated above.

12. I understand if I am involved in any court matters, legal matters and / or any other situations requiring involvement from my therapist, there may be additional costs incurred for any reports, appearances or consultations by my therapist as outlined in my therapist's fee schedule.

Parent/Legal Guardian Signature: _____ Date: _____
(If client is under age 18)

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Revised 04/27/14

Client Name: _____

Resolutions

Individual, Couple and Family Therapy

Waiver of Medical / Psychiatric Consultation

I understand that under the provisions of KSA 65-6404 (b) my therapist is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder he or she may have observed while working with me or my minor child(ren) listed below:

Primary Client's Name: _____

If you have minor children who will be attending Family Therapy sessions with you please list their names below.

Name of Minor Child: _____

Name of Minor Child: _____

Name of Minor Child: _____

In the event I or my child(ren) do not have a primary care physician, I acknowledge my therapist has / will have recommended I seek a medical consultation.

By signing below I am indicating that I waive my right to a medical consultation with my primary care physician by my therapist and I am aware this waiver will become part of my client record.

Parent/Legal Guardian Signature: _____ Date: _____
(If client is under age 18)

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Revised 04/27/14

Client Name: _____

Resolutions

Individual, Couple and Family Therapy

Acknowledgment of Receipt of Notice of Privacy Practices

(To be completed by parent or legal guardian if client is under age 18 or is a disabled dependent)

I, _____, do hereby acknowledge I reviewed and was offered a copy of the Notice of Privacy Practices, Policies and Procedures of Resolutions, Individual, Couple and Family Therapy, LLC.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____
(If client is under age 18)

Relationship to Client (please circle): **Parent** **Legal Guardian** **Power of Attorney**

Witness Signature: _____ Date: _____

Client Name: _____

Resolutions

Individual, Couple and Family Therapy

Office Payment Policy

Client

Name: _____ _____ _____
First MI Last

Financially Responsible Party

Name: _____ _____ _____
First MI Last

Relationship to Client (please circle): **Self** **Parent** **Legal Guardian** **Power of Attorney**

Insurance

Due to the large proliferation of insurance carriers and their constantly changing policies, we are unable to determine your exact insurance coverage. We can only provide you with general plan information provided to us by your insurance company. For your protection, we recommend that you not assume you have coverage without contacting your insurance carrier yourself. To avoid unexpected charges, check with your agent prior to treatment.

We require your co-payment and deductible (if applicable) on the date of service. Your co-payment is only an estimate. Your final portion will be due once insurance has paid on your visit (which may usually take between 2-8 weeks for payment on the claim). Please remember that ultimately, you are financially responsible for the services you receive here, regardless of what your insurance company says they will or will not pay.

No Insurance

People who do not have insurance will be required to pay in full on the day of treatment. If your circumstances require a payment plan, a meeting with the Director of Operations may be necessary. We accept Visa, MasterCard, personal or cashier's checks and cash.

Cancellation Policy

24 HOURS NOTICE IS REQUIRED TO RESCHEDULE OR CANCEL ANY APPOINTMENT.
If you fail to provide the required 24 hours of notice for a cancellation YOU WILL BE BILLED (and responsible for) THE ENTIRE AMOUNT OF THE SESSION YOU MISSED.

I understand and agree to the above terms and conditions.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Financially Responsible Party Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Revised 04/27/14

Client Name: _____

Resolutions

Individual, Couple and Family Therapy

Client Rights and Responsibilities Acknowledgement

I acknowledge that I have received a copy of my client rights and responsibilities provided by Resolutions Individual, Couple and Family Therapy, LLC.

_____ _____

Signature of Client or Responsible Party Date

Client Name: _____

Resolutions

Individual, Couple and Family Therapy

Client Rights and Responsibilities

- Receive Information: Each Member has the right to receive information about their insurance company, their policies and procedures, services, practitioners and providers, and the Members rights and responsibilities.
- Dignity and Privacy: Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options: Each Member is guaranteed the right to receive information on medically necessary available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- Participate in decisions: Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- Free from restraint or seclusion. Each Member is guaranteed the right to be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Copy of medical records: Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request they be amended or corrected as specified in 45 CFR part 164.
- Free exercise of rights: Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Member is treated by the insurance company or the provider.
- Freedom to Change Provider. The insurance company shall not impose any limitation on the Member's freedom to change mental health providers.

Members have the additional rights and responsibilities:

- To choose his/her Provider (within the network)
- To ask for a therapist who understands his/her language and culture
- To receive needed services at convenient times and places
- To obtain access to services within the specified access standards
- To treat others with consideration and respect
- To be at appointments on time
- To call if he/she must cancel
- To be part of the treatment team by telling your doctor or therapist about symptoms and to ask questions
- To tell the doctor or therapist if you do not agree with recommendations
- To tell the doctor or therapist when/if you want to end treatment
- To take medication as prescribed and to tell the doctor if there is a problem
- To carry his/her insurance cards
- To tell the Provider if they have other insurance
- To follow plans and instructions for care that they have agreed on with Providers