Resolutions
Individual, Couples and Family Therapy

COVID-19 CLIENT QUESTIONNAIRE AND ACKNOWLEDGEMENT FORM

Name: _____ Date: _____

Temperature Reading: _____ Initials/Read by: _____

To our valued clients:

The State Health Department and the Centers for Disease Control and Prevention have set specific guidelines to prevent the spread of the COVID-19 virus. We at Resolutions Therapy have therefore implemented these standardized procedures to best protect our staff and our clients. While we are committed to providing the best care possible, we are unable to make any guarantees regarding perfection of office and personal sanitization.

Our staff remains symptom free and, to the best of our knowledge, has not been exposed to the Coronavirus. Given that we operate a public place of service, other persons entering the premises may be silent carriers and unaware of it. Therefore, in order to reduce the risk of spreading COVID-19, we request your responses to screening questions presented below. For the safety of our team, other clients, and yourself, please be truthful and careful in your answers.

Have you tested positive for COVID-19 in the past 14 days? ☐ Yes ☐ No

Have you been exposed to anyone with suspect or confirmed COVID-19 in the past 14 days? ☐ Yes ☐ No

Have you traveled out of the area, country or state in the last 14 days? ☐ Yes ☐ No

Have you experienced any of the following in the last 14 days? ☐ Yes ☐ No

Symptom	Yes	No
Fever	☐	☐
Cough	☐	☐
Headaches	☐	☐
Chills	☐	☐
Shortness of breath	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐

Symptom	Yes	No
Unexplained muscle pains	☐	☐
Sore throat	☐	☐
Loss of taste or smell	☐	☐
Pain or pressure in your chest	☐	☐
New confusion	☐	☐
Bluish lips or face	☐	☐
Difficulty in awakening	☐	☐

I acknowledge that while my therapist's office and associated staff is employing best practice standards to maintain excellent environmental and personal hygiene, it is not possible to ensure a completely germ-free environment from the potential exposure to COVID-19 (Coronavirus). I have been given the option to defer my treatment to a later date or to engage in teletherapy. I understand the potential risks regarding in person treatment including potential short-term and long-term complications related to COVID-19. Nevertheless, I prefer to proceed with today's scheduled appointment.

Client Name (printed): _____

Client Signature: _____

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NAME: _____ _____ _____
First *Middle* *Last*

DATE OF BIRTH: ____/____/____ **BIRTH GENDER:** ☐ *M* ☐ *F* **IDENTIFIES AS:** ☐ *M* ☐ *F*

SOCIAL SECURITY NUMBER: ____/____/____ **DRIVER'S LICENSE NUMBER:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

HOME PHONE: _____ **CELL:** _____ **EMAIL:** _____

***Calls or emails will be discreet, but please indicate any restrictions*:** _____

_____

Care for a text or email reminder for your appointments? ☐ **Text** ☐ **Email** ☐ **Neither**

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

WORK PHONE: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CARRIER: _____

Group Number: _____ *Policy Number*: _____

PRIMARY PERSON INSURED: (*name as it appears on the card*): _____

Address: _____

Telephone Number: ___-___-____ *EMail*: _____

Date of Birth: ____/____/____

SECOND INSURANCE CARRIER (IF APPLICABLE): _____

Group Number: _____ *Policy Number:* _____

PRIMARY PERSON INSURED: (*name as it appears on the card*): _____

Address: _____

Telephone Number: ___-___-____ *EMail*: _____

Date of Birth: ____/____/____

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CURRENT SYMPTOM CHECKLIST

Please rate the intensity of the symptoms and check all that apply

SYMPTOM KEY:

MILD = Impacts quality of life, but no significant day to day impairment
MOD (Moderate) = Significant impact on quality of life and/or day to day functioning
SEV (Severe) = Profound impact on quality of life and/or day to day functioning
PAST = Experienced in the past, but not within the prior 6 months

CLIENT NAME_____

SYMPTOM	MILD	MOD	SEV	PAST	SYMPTOM	MILD	MODE	SEV	PAST
Depressed Mood	☐	☐	☐	☐	Worthlessness	☐	☐	☐	☐
Appetite Increase/Decrease	☐	☐	☐	☐	Guilt	☐	☐	☐	☐
Sleep Less/Too Much	☐	☐	☐	☐	Elevated Mood	☐	☐	☐	☐
Bowel or Urinary Issue	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Fatigue / Low Energy	☐	☐	☐	☐	Dissociative states	☐	☐	☐	☐
Feeling Slowed Down	☐	☐	☐	☐	Physical & Bodily Complaints	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐	Self-Mutilation	☐	☐	☐	☐
Poor Grooming	☐	☐	☐	☐	Significant Weight Loss or Gain	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	Medical Conditions	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Emotional Trauma Victim	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Physical Trauma Victim	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Sexual Trauma Victim	☐	☐	☐	☐
Generalized Anxiety	☐	☐	☐	☐	Emotional Trauma Victim	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐	Emotional Trauma Perpetrator	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	Physical Trauma Perpetrator	☐	☐	☐	☐
Obsessions and/or Compulsions	☐	☐	☐	☐	Sexual Trauma Perpetrator	☐	☐	☐	☐
Bingeing and/or Purging	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Laxative/Diuretic abuse	☐	☐	☐	☐	Suicidal/Homicidal Thoughts	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	Racing Thoughts	☐	☐	☐	☐
Paranoid ideations	☐	☐	☐	☐	Poor Task Completion	☐	☐	☐	☐
Thought disorders	☐	☐	☐	☐	Learning Disability	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Developmental Disability	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Property Destruction	☐	☐	☐	☐
Aggressive behavior	☐	☐	☐	☐	Social Awkwardness	☐	☐	☐	☐
Childhood Behavior Problems	☐	☐	☐	☐	Gambling	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐	Relationship Conflicts	☐	☐	☐	☐
Grief	☐	☐	☐	☐	Infidelity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Muscle Tension	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐	Impulsivity	☐	☐	☐	☐
Other:						☐	☐	☐	☐

Current reason for seeking therapy: _____

Current prescription medications taken (dose and frequency): _____

_____

Primary Care Physician (name and telephone number): _____

Current medical issues, if any: _____

Past medical issues (head trauma, surgeries, accidents, etc.): _____

_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
HIPPA COMPLIANCE PATIENT CONSENT

This form is to be completed by a parent or legal guardian if the client is under age 18 or is a disabled dependent

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

_____ Date: _____
Client Signature

_____ Date: _____
Signature of Responsible Party (client < age 18 / dependent)

Relationship to Client (check): ☐ Parent ☐ Legal Guardian ☐ Power of Attorney

_____ Date: _____
Signature of Witness

INFORMED CONSENT AND THERAPY CONTRACT

Resolutions Individual, Couple, & Family Therapy, LLC believes that every person holds within them the ability to resolve problems and achieve their individual human potential. Our responsibility is to assist clients in applying their personal resources to achieve their goals. In therapy, we will work collaboratively to assist you in designing appropriate goals and effecting behavioral changes that will positively impact your life.

Please know that for therapy to be effective, *it takes dedication and effort*. We regularly provide assignments that will be crafted specifically for you and expect that you will take the necessary time to complete them prior to your next scheduled session. We anticipate our work together to place you on a path to personal transformation and healing, and we look forward to a mutually rewarding therapeutic experience.

Kindly review the following and place your signature where requested to confirm your understanding and acknowledgement of the following:

- I can leave therapy at any time and agree to discuss the termination of services with my clinician.
- If I am unable to attend a session, I will inform the Resolutions at least 24 hours in advance. Not doing so will result in my being billed for a $50 late cancelation or no-show fee.
- I agree to ensure payment of the clinical hourly rate associated with my treatment and accept responsibility for all unpaid balances and/or denied claims by all third-party payers.
- I agree to complete an Authorization to Release Information to allow my therapist access to my primary care physician and all other appropriate service providers as needed for continuity of care.
- My therapist is working as a contracted provider for Resolutions Individual, Couple & Family Therapy, LLC.
- I agree and permit the sharing of all information needed with third party billing and/or collection services in order to keep my account current.
- I allow Resolutions Therapy the authority to charge and assess collection costs and expenses, including reasonable attorneys fee, penalties and interest associated with nonpayment.
- I understand Resolutions Therapy utilizes Therasoft, an online billing, collection and file management system for records administration. I allow Resolutions Therapy to share all data pertinent in the maintenance of my records with Therasoft and its employees, who are strictly bound by confidentiality and accepted ethical standards as it applies to mental health treatment.
- Confidentiality may be broken when it is believed that:
    - I am in danger or that I am a danger to myself and/or others,
    - A child, elderly, or disabled person was, may be, or is subject to abuse or neglect,
    - Continuity of care, case management, or clerical services are needed, and/or
    - A court order exists that requires information disclosure regarding my therapy process.

Client Signature: _____ Date: ____/____/

Parent or Legal Guardian Signature: _____ Date: ____/____/

Witness Signature: _____ Date: ____/____/

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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: _____

Witness Signature: _____ Date: _____

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OFFICE PAYMENT POLICY

_____ FINANCIAL POLICY

Initials

The Mental Health provider you are seeing today has contracted with a variety of insurance companies. We also provide services for private pay clients. We will submit claims, on your behalf, to your primary insurance carrier, as well as, secondary and tertiary carrier (if applicable). Our office does not contract with health share plans, auto, or liability insurance companies. **Payment is required at the time of service.**

Please remember your health insurance is an agreement between you and your insurer. **It is your responsibility to know and understand coverage, benefits, and requirements of your health plan**. If you would like us to submit a claim for your services, you must provide current insurance information prior to the time of service.

If your health insurance requires a deductible, co-insurance, or copay, you will be required to pay for that amount in full at the time of service. We accept cash, check or credit card. If you are not prepared to pay the required amount at the time of service, you will be required to reschedule your visit. Our office reserves the right to refuse to schedule future appointments until the entirety of your bill has been paid.

Our office does not offer long-term financing of balances for healthcare we provide. Limited payment plans may be available (but are not guaranteed) and must be approved by the billing office. In the event that your bill is not paid timely, we will charge your credit card on file.

_____ CREDIT CARD AUTHORIZATION POLICY

Initials

Our policy requires that a credit card must be saved on file prior to being seen by our providers. **This card will be charged for appointment copay, co-insurance, and deductible amounts at the time of service.** Private pay fees will also be collected at the time of service. Additionally, the card will be charged if your account has a balance more than 30 days past due. If you do not provide a debit, credit or health savings card, and a cash payment is not provided prior to being seen by our providers, it may be necessary to reschedule your appointment and it might result in not being able to schedule future appointments until a valid card is saved on file.

The security of your information is of utmost importance. Your card information is stored by our software. Our staff does not have access to your card information after it is entered into the database.

_____ MISCELLANEOUS FEES AND BILLING

Initials

In addition to our professional fees, you may be charged for phone conversations, writing letters, court preparation and appearance. All FMLA forms are $50.00 to complete (They will not be returned or forwarded until paid in full). It is our policy to charge for appointments that are not canceled 24 hours in advance and for appointments that are not kept. Insurance does not pay for missed appointments. We reserve the right to charge $50 for missed appointments, and appointments cancelled without 24 hr notice. Appointments missed because of inclement weather or other major problems will not be charged. Your charge will be applied to your credit card on file.

For any questions regarding billing information, call between 8-5 Mon through Thursday.

Client's Printed Name _____

Signature _____ Date:_____

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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

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