The Right Solution Counseling Services

www.rightsolutioncounseling.com
314-374-1620

CLEAR FORMS

Date Received: _____

Client Information:

First Name: _____ Middle _____ DOB: _____ Age: _____

Last: _____ Preferred Name/Pronouns: _____

Address: _____

City/State/Zip: _____

Cell#: _____ Home#: _____ Work#: _____

Permission to provide detailed messages at cell phone # listed above: ☐ Yes ☐ No

Permission to provide an Appointment Reminder by Email & Text: ☐ Yes ☐ No

Email: _____ Cell#: _____

Permission to email bills / newsletters / flyers: ☐ Yes ☐ No _____

Emergency Contact: _____ Relationship: _____ #: _____

How did you hear about us? _____

- Are you seeking therapy due to an active court case, police investigation or court ordered? ☐ Yes ☐ No

  Name of Attorney or Guardian ad Litem: _____

Please be aware that court related sessions or expenses will NOT be billed to health insurance _____ (initials)

Primary Insurance Company

Insurance (or) EAP Company: _____ Authorization #: _____

Policy Holder (full name): _____ DOB: _____

Secondary Insurance (if applicable)

Insurance (or) EAP Company: _____ Authorization #: _____

Policy Holder (full name): _____ DOB: _____

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FINANCIAL RESPONSIBILITY – FEES – ASSIGNMENT – RELEASE OF INFORMATION

Clients Name: _____ DOB: _____
(full name)

Financial Responsibility: The undersigned responsible party agrees to pay The Right Solution, Inc. for services rendered to the above-named client. By signing this form, which includes a statement about financial responsibility, I, as the client and/or guardian of the client, agree I am responsible for payment of services rendered in any case in which payment is denied by companies, insurance, managed care insurance, health maintenance organizations and preferred providers because of failure to comply with such coverage requirement or for any other reason. It is the client's, and/or guardian of the clients, responsibility to verify insurance benefits and provide an authorization number on the first visit.

- **CO-PAYMENTS: By law we MUST collect your carrier designed co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5 may be added to your account.**
- **DIVORCED/SEPARATED PARENTS OF MINOR CLIENTS: The parent who consents to the treatment of a minor child is responsible for payment of services rendered, The Right Solution Inc. will not be involved with separation or divorce disputes.**

Fee for Services Schedule (45 - 50 minute session)**:**

• Assessment:	$160.00
• Individual/Family/Couples session:	$110.00
• Telehealth:	$110.00
• Co-Parenting Counseling	$160.00
• Any court related Consultations/sessions:	$160.00
• Letters	$ 50.00
• Returned check fee	$ 50.00
• Late payment fee:	$ 30.00 – if payment more than 45 days past due

- Telephone calls over 15 minutes will be charged at the rate of $150.00 an hour and will be billed in 10 minute increments.
- **Case Management** (including but not limited to emails, letters/reports, phone calls, record preparation): $150.00 an hour.
- **Court involvement**: Any and all court involvement, including but not limited to court appearances, trials, depositions, testimony or consultation - $200 an hour (port to port) 4 hour minimum. To be paid three (3) business days prior to the court date. **Fees charged for court involvement that are cancelled or postponed without advance notice of at least one (1) full business day/24 hrs notice are not refundable.**

Missed/Cancelled Appointments: Please notify us 24 hours in advance of any appointments you are unable to keep. **Appointments cancelled with less than 24 hrs notice -or- No show/missed appointments will be charged a fee of $40.**

Returned Checks Fee: Returned Checks will incur a $50.00 service charge – no exceptions. Any future payments will ONLY be accepted in the form of cash and/or credit card.

Payments: Payment is due at the time of service unless other arrangements have been made. You are responsible for deductibles, co-insurance and co-payments. It is your responsibility to familiarize yourself with your insurance benefits. If your account has not been paid for more than 60 days and arrangement for payment have not been agreed upon, The Right Solution, Inc. has the option of using legal means to secure payment. This may involve hiring a collections agency or going through small claims court. If such legal action is necessary, the costs will be included in the claim. In most collections situations, the only information released includes: name, address, work/home phone numbers, nature of services rendered and the amount due.

Excessive Account Balances: If account balances exceed $150, counseling services may be suspended or discontinued until payment has been made. Please feel free to inquire about payment plans.

Assignment and Release of Information: The client and/or financially responsible party assume the responsibility to provide current and accurate insurance data necessary to file claims. **It is the responsibility of the client or financially responsible party to verify their insurance benefits**. I authorize The Right Solution, Inc. to release medical information to my insurance company. I authorize and request insurance payments be made directly to The Right Solution, Inc. for services otherwise payable by the client and/or client's guardian. I also acknowledge I have received a copy of the information included above upon my request.

Signature _____ Date _____
Client or responsible party

Print Full Name: _____

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INFORMED CONSENT FOR TREATMENT

Welcome! Thank you for choosing to begin the counseling process at The Right Solution, Inc. This is an opportunity to acquaint you with information relevant to treatment, confidentiality, office policies and to notify you of privacy practices regarding your information. Your therapist will answer any questions regarding any of these policies.

Sessions are typically 45 - 50 minutes in length, but your first appointment may take an hour.

Patients are generally seen weekly, biweekly or less/more frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist.

Aims and Goals: The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This is sometimes accomplished by:

- *Identifying personal treatment goals*
- *Increasing personal responsibility and acceptance to make changes necessary to attain your goals*
- *Increasing personal awareness*
- *At times addressing difficult emotional situations that may be causing you distress*

You are responsible for providing necessary information to facilitate effective treatment and to play an active role in your treatment, including working with your therapist to outline goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session. Some individuals may experience an increase in symptoms as discussing long-standing unresolved problems may bring out difficult emotions.

Office hours: Monday - Thursday 8am-6pm & Friday 8am-12pm You may leave a message 24/7. Messages are checked regularly, including weekends.

Emergencies: Life threatening emergencies call 911 or go to your local emergency room. Call 24/7 the National Suicide hotline 1-800-273-8255. For crisis' or to speak with a counselor call 24/7 St. Louis Behavioral Health Response at 1-800-811-4760 or the Missouri Suicide Crisis Lifeline by dialing 988.

Record Keeping: A clinical chart is maintained regarding treatment and progress in treatment, dates of and fees for sessions, and notes for each therapy session.

Educational experiences: The Right Solution, Inc. participates with local universities to offer practicum/internship opportunities to graduate students working towards a Master's Degree. With your permission, this may include an intern or provisionally licensed counselor/social worker observe or co-facilitate your session. All interns have signed a confidentiality agreement. If at any time you do not wish for an intern to be present please advise your therapist.

Complaints: You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, therapist or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved you may speak to the Clinical Director or President, or you may also inform your insurance carrier and file a complaint if you so choose.

Excessive Account Balances: If account balances exceed $150, counseling services may be suspended or discontinued until payment has been made. Please feel free to inquire about payment plans.

Notice of Privacy Practices & Confidentiality Limits: While issues discussed in therapy are generally confidential there are limits, such as but not limited to - suspected abuse or neglect of a child, elderly person or disabled person; when we believe you are in danger of harming yourself or harming another person or you are unable to care for yourself; if you report that you intend to physically injure someone the law requires we inform that person as well as legal authorities; if your psychiatrist or therapist is ordered by a court to release information; when otherwise required by law. **The Notice of Privacy Practice brochure addresses how The Right Solution, Inc. may use and disclose your medical/mental health information, as well additional confidentiality limits. Please read it carefully.**

- Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section & Notice of Privacy Practices. You may be asked to sign a Release of Information so that your therapist may speak with other professionals or your family members. For those attending couples counseling, both parties must sign a release of information for a record to be released.
- Clients who do not attend counseling for more than 30 days will be automatically discharged from treatment, though you are welcome to return to treatment at any time.
- Clients who do not show for scheduled appointments or continue to cancel appointments without giving 24 hours' notice will be discharged and have services discontinued.
- **Privacy Policy Prohibiting Audio and Video recording**: For the protection of client privacy, The Right Solution, Inc. does not allow, agree to or permit audio or video recording of sessions or phone calls by clients or other outside parties.
- **Court Involvement**: Any and all court involvement, including but not limited to court appearances, trials, hearings, depositions, testimony or consultation - **$200 an hour (port to port) 4 hour minimum**. This fee for court services must be paid three (3) business days prior to the court date. Fees charged for court involvement that are cancelled or postponed without advance notice of at least one (1) business day with 24hrs notice are not refundable. Monday dates must be changed by 11am on the preceding Friday. The parent/client/guardian hereby agrees to pay these charges, including the costs of collecting unpaid fees, under the terms set by this agreement.
- **COVID-19**: The Right Solution, Inc. is following CDC guidelines to prevent COVID-19, such as the cleaning and sanitization of our facility; social distancing; monitoring for the presence of symptoms.

__(initials)___ If parents/guardians have joint custody, both parents will need to give permission for their child/teen to attend counseling sessions.

__(initials)___ **Cancelled Appointments/No Shows**: Should you need to cancel/reschedule an appointment we require a 24 hour notice. You may leave a message 24 hrs a day. Appointments cancelled with less than 24 hours' notice -or- no show/missed appointments may be **charged a fee of $40.00**.

__(initials)___ **I was offered a copy of the 'Notice of Privacy Practices' brochure.** (Copies can be found at the receptionist desk)

I have read, understand and agree to abide by the contents and terms of the Consent for Treatment form. I have had any questions and/or concerns answered to my satisfaction regarding the Consent for Treatment & the Notice of Privacy Practices. I have received a copy of the Consent for Treatment form upon my request. I further consent to participate in the evaluation/assessment and/or treatment process. I understand I may discontinue treatment at anytime.

_____ _____

Signature Witness

_____ _____

Print Name Date

CLICK HERE TO VIEW THE PRIVACY PRACTICE BROCHURE

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CHILD OR ADOLESCENT CLIENTS UNDER AGE 18

Responsible Party Information

Parent/Guardian Name: _____ DOB: _____

Mailing Address: _____

City/State/Zip: _____

Relationship to client: _____ Email: _____

Cell #: _____ Home#: _____

Treatment Consent for Child or Dependent

I am the legal guardian or legal representative of the patient. On the patient's behalf I legally authorize the practitioner/group of The Right Solution, Inc. to deliver mental health counseling services to the patient. I also understand that all policies, procedures, Informed Consent and Notice of Privacy Practices apply to the patient I represent.

_____ _____
Patient Name Patient DOB

_____ _____
Signature of Legal Guardian/Legal Representative Date

_____
Relationship to Patient

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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals and remote patient monitoring are all considered telehealth services.

_____ I understand telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at The Right Solution.

_____ I understand telehealth services can only be provided to patients, including myself, who are residing in the state of Missouri at time of service.

_____ I understand telehealth billing information is collected in the same manner as regular office visits. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____ I agree information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm he or she is my healthcare provider.

_____ I understand electronic communication cannot be used for emergencies or time sensitive matters. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit. To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Witness Signature

_____	_____
Print Name	Date

The Right Solution Counseling Services

Date Received: _____

Client: _____ **Age:** _____ **DOB:** _____ **Gender:** _____

Employer/School _____ **Occupation/Grade** _____

Person filling out form (name/relationship):_____

Education: Check highest level completed: ☐ Elementary ☐ Junior High ☐ High School

☐ Trade/Technical School ☐ College - Degree Received? If Yes, what degree: _____

DESCRIPTION OF PRESENTING PROBLEM

Reason for seeking counseling: _____

Current Problem: (check all that apply)

☐ Marital
☐ Stress
☐ Depression
☐ Anxiety
☐ Anger
☐ Substance Abuse
☐ Behavioral
☐ Social Skills
☐ Social Withdrawal
☐ Family Related Issues
☐ Relationship problems
☐ School/Work Performance
☐ Bullying
☐ Obsessive or Compulsive _____
☐ Fears of: _____
☐ Traumatic event: _____
☐ Other – Explain: _____

Approximately how long have these been a problem? _____

Problem Intensity: How would you rate the intensity of the problem or concern that brought you in?

Not Intense — Moderately Intense — Extremely Intense

1 ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐

Please list at least two goals or things you hope to accomplish by coming to counseling:

1. _____
2. _____

Over the last 2 Weeks how often have you been bothered by the following:

- Little interest or pleasure in doing things: NOT AT ALL
- Feeling down, depressed or hopeless: NOT AT ALL

COUNSELING HISTORY

Previously attended counseling: ☐ Yes ☐ No

Name of counselor	When (month/year)?	# of sessions	Problem addressed	Helpful? (Y/N)

PSYCHIATRIC HOSPITALIZATIONS

Psychiatric hospitalizations? ____ Yes ____ No

Name of **facility/hospital**	When (month/year)	Length of stay	Reason for hospitalization	Diagnosis

HEALTH/MEDICAL INFORMATION

- Are you currently being treated for any infectious diseases? ____ Yes ____ No (e.g. hepatitis, chicken pox, mumps, measles.

  Please list: _____
- Any food or medication allergies? _____
- Any medical conditions - persistent physical symptoms? ____ Yes ____ No (e.g. diabetes, asthma, heart conditions, hypertension, chronic pain headaches)

  Please list:_____
- Current Medication? Medication – Dosage – Purpose - Prescribing Doctor(s): _____

  _____
- Sleep? ____ No Sleep issues ____ Sleeping too little ____ Too much ____ Poor quality ____ Stressful dreams
- Appetite? ____ No Appetite issues ____ Eating less ____ Eating more ____ Binging ____ Purging ____ Restricting

---

LIFESTYLE INFORMATION

- Recreational drug use? ____ Yes ____ No; ____Daily ____Weekly ____Monthly ____Rarely; Drug used: _____

  Do you consider this drug use a problem? ____ Yes ____ No; _____
- Alcoholic beverages per week: _____ Consider your alcohol consumption a problem? ____ Yes ____ No
- Past Alcohol or Substance Abuse issues? ____ Yes ____ No; If yes, explain: _____
- Alcohol or Substance Abuse issues in the last *30 days*? ____ Yes ____ No; If yes, explain: _____
- Do you use any Nicotine products? ____ Yes ____ No; ___ Cigarettes ___ Chew ___ Vaping ___Other: _____

  If yes, are you ready to discontinue use of Nicotine products? ____ Yes ____ No
- Anyone at home (other than yourself) using Nicotine? ____ Yes ____ No ; If yes, explain: _____
- Number of hours of sleep per night (average): _____
- Any current or past issues with Gambling? ____ Yes ____ No; If yes, explain: _____
- Do you have a problem with your weight? ____ Yes ____ No; If yes, explain: _____
- Spiritual or Religious Affiliations? _____

- Current Domestic Violence? ____Yes ____ No; If yes, explain: _____
- Past Domestic Violence? ____ Yes ____ No; When: _____
- Quality of social relationships? ____ Excellent ____ Good ____ About Average ____ Unsatisfactory ____ Poor
- Approximately how many people can client really count on for friendship and/or emotional support? _____
- Current or Past legal problems? ____ Yes ____No; If yes, please explain: _____

- Agencies/Support systems involved with you or your Family? ____ Yes ____ No (e.g. Children's Division, Juvenile office, Community Agencies, Probation/parole, etc.)

  If yes, explain: _____

SIGNIFICANT LIFE EVENTS and/or FAMILY TRAUMA

Please check any issues/problems you feel may be affecting you:

____ Financial crisis/unemployment ____ Deaths ____ Divorce

____ Physical/sexual abuse ____ Legal problems ____ Frequent relocations

____ Emotional Abuse ____ Eating disorders ____ Attempted/completed suicides

____ Alcohol/drug abuse ____ Debilitating injuries/disabilities

____ Serious Illness/Family Health issues within the family - Please list: _____

_____

FOR CHILDREN 12 & UNDER:

Social & Behavioral:

- Regularly complains of aches and pains when they are not sick? ____ Yes ____ No
- Problems with frequent lying? ____ Yes ____ No
- Problems with blaming others? ____ Yes ____ No
- Child's social interaction: (check all that apply) ____ Easily makes friends ____ Difficulty making friend
  ____ Difficulty keeping friends ____ Appears uninterested in friends ____ Prefers to have only one friend
  ____ Follower ____ Leader ____ Prefers to play alone
- How would you describe your child's feelings about school: (check all that apply) ____ Enthusiastic ____ Eager
  ____ Passive ____ Bored ____ Fearful ____ Anxious ____ Rebellious ____ Other _____
- Child's approach to school work? (check all that apply) ____ Organized ____ Responsible ____ Perfectionist
  ____ Disorganized ____ Sloppy ____ No Initiative ____ Does only what is expected
  ____ Doesn't complete assignments
- Does your child cause serious harm to others or any animals? ____ Yes ____ No; _____
- Other Behavioral Issues? _____

PRINT FORMS SAVE EMAIL FORMS