

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 the cellphone # listed above: ___Yes ___No

> Appointment Reminder: Permission to provide Reminders by Email or Text: ___Yes ___No

Email: _____ Text phone #: _____

> 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: _____

Relationship to client: _____ SS#: _____

Employer: _____ Cell #: _____ Home #: _____

Secondary Insurance (if applicable)

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

Policy Holder (full name): _____ DOB: _____

Relationship to client: _____ SS#: _____

Employer: _____ Cell #: _____ Home #: _____

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: _____

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.

Emergencies: Office hours: Monday - Thursday 9am-7pm & Friday 9am-1pm

Life threatening emergencies call 911 or go to your local emergency room. Call 24/7 the National Suicide hotline at 800-273-8255. For crisis' call 24/7 St. Louis Behavioral Health Response at 1-800-811-4760. For non-life threatening after hours - call 314-709-6099. This information is included on the Main office voicemail.

Record Keeping: A clinical chart is maintained describing your condition, 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 that 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

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

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit such as by video or telephone conferencing.

- I agree to receive mental health services through interactive video or phone conferencing. I understand the use of video and phone is an alternative method of mental health care delivery and that my therapist will not physically be in the same room with me. I understand that telehealth services may not be as complete as services provided face-to-face. I understand that my participation in telehealth services is voluntary, and I may decide to discontinue telehealth appointments at any time. This will not change my ability to receive future care at The Right Solution. If my therapist believes I would be better served by another form of counseling services (e.g., face-to-face services), they will discuss this with me and if necessary, provide referrals.
- I understand that by using telehealth services, transmissions over the internet are at my own risk. I am aware that the possible risks/consequences of telehealth include but are not limited to - third parties may unlawfully intercept or access transmissions over the internet, disrupted or distorted technical failures may occur, and electronic systems that are accessed by employers, friends or others are not secure and should be avoided. I understand I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- I understand that my healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I understand telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s) and it is my responsibility to check with my insurance plan to determine coverage.
- I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Missouri at time of service.
- I agree to verify my identity and current location prior to starting telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand there will be no recordings made of my sessions, as The Right Solution, Inc. does not allow, agree to or permit audio or video recording of sessions or phone calls. I agree not to record my sessions or allow an outside party to record my sessions.
- 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 have read this document in full, agree to understand the inherent risks of errors or deficiencies in the electronic transmission of health information 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

Client Name: _____ **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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Marital | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Bullying |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Social Skills | <input type="checkbox"/> Obsessive or Compulsive _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Social Withdrawal | <input type="checkbox"/> Fears of: _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Family Related Issues | <input type="checkbox"/> Traumatic event: _____ |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Other – Explain: _____ |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> School/Work Performance | |

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:
- Feeling down, depressed or hopeless:

COUNSELING HISTORY

Previously attended counseling: ___ Yes ___ No

| | | | | |
|--------------------------|---------------------------|----------------------|--------------------------|-----------------------|
| <u>Name of counselor</u> | <u>When (month/year)?</u> | <u># of sessions</u> | <u>Problem addressed</u> | <u>Helpful? (Y/N)</u> |
|--------------------------|---------------------------|----------------------|--------------------------|-----------------------|

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? _____