Wings of Courage FAMILY SERVICES COUNSELING & PRESENTATIONS ....Journey of Truth

CLIENT INFORMATION

Date: _____

Name: (Last) _____ (First) _____ (Middle) _____

Address: (Street) _____ (City) _____ (State) _____ (Zip) _____

Age: _____ **Birthdate**: _____ **Sex**: ☐ M ☐ F **Marital Status**: ☐Married ☐Single ☐Divorced ☐Widowed

Employed: ☐Yes ☐No **Work Phone**: ( ) _____ **Home Phone**: ( ) _____

Employer (if employed): _____

Address: (Street) _____ (City) _____ (State) _____ (Zip) _____

Name of Spouse (if married):

(Last) _____ (First) _____ (Middle) _____

Address, if different from above:

(Street) _____ (City) _____ (State) _____ (Zip) _____

Age: _____ Birthdate: _____ Social Security #: _____

Employed: ☐Yes ☐No Office Phone: ( ) _____ Home Phone: ( ) _____

Name of Employer (if employed): _____

Employer Address: (Street) _____ (City) _____ (State) _____ (Zip) _____

Do you have any children?* ☐Yes ☐No If Yes, please list below. ***If children are from a previous marriage, please indicate.***

Name	Age	Birthdate	Living at Home?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

INSURANCE INFORMATION:

Insurance Company: _____

Subscriber Name: _____ D.O.B. _____

Subscriber/Member ID #: _____ Group #: _____ Plan Code: _____ Other: _____

Any other insurance? ☐Yes ☐No If Yes, name of insurance: _____

Subscriber Name: _____ Subscriber/Member ID#: _____

Group #: _____ Plan Code: _____ Other: _____

AUTHORIZED RELEASE: I authorize the release of any medical or other information necessary required to process the insurance benefit claims. I also request payment of government benefits either to myself or the party who accepts assignment below. A photocopy of this release may be honored. Signature of Insured: _____ Date _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the undersigned physician or supplier for services listed on the insurance claim form.

Signature of Insured _____ **Date** _____

YOUR EMAIL PLEASE FOR COURTESY APPOINTMENT REMINDERS: _____

I **UNDERSTAND AND CONSENT** to being **CHARGED MY FULL FEE** for any sessions if **I FAIL TO GIVE 24 HOURS NOTICE PRIOR** to my scheduled appointment. I am willing to take full responsibility for services rendered at $150.00 per 50-minute session or the agreed upon fee that my insurance company has contracted with the provider.

I understand and am personally responsible for any debts incurred for services rendered to me by my provider of service. I understand that the purpose of insurance carrier coverage is to provide me with a partial or complete reimbursement for fees for services rendered to me. This reimbursement is governed by the policy covering me. I understand that the insurance company is not obligated for debt I incur for professional services rendered to me.

I understand that my provider of service may be providing the service of processing my claims but is not guaranteeing reimbursement by my insurance carrier for claims submitted on my behalf. I am fully responsible for this financial obligation. I have read and understand the financial policies of this financial statement/agreement and I accept the terms of my financial responsibilities as indicated by my signature below.

SIGNATURE: _____ DATE: _____

MEDICAL HEALTH HISTORY

Primary Care Physician:_____ Telephone: (____)_____

Address:_____

	YES	NO
1. Have you had any past health problems, hospitalizations or surgeries?	☐	☐
If Yes, please explain:		
2. Do you have any known present health problems?	☐	☐
If Yes, please explain:		
3. Are you currently taking any medications?	☐	☐
If Yes, please list the medications you are presently taking:		

4. Name(s) of doctor(s) presently treating you: _____

5. What faith do you practice?
(0ptional)_____

6.. Have you ever received counseling? ☐ ☐

If Yes, please give the name of your Counselor and dates of service:

7.. Are you experiencing any of the following symptoms:

- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Weight Change
- ☐ Isolation
- ☐ Obsessive/Compulsive
- ☐ Aggressive Behavior
- ☐ Assaultive Behavior
- ☐ Conduct Disorder
- ☐ Attention Problems
- ☐ Concentration Difficulty
- ☐ Confusion
- ☐ Dizziness, light-headedness
- ☐ Hallucinations: [ ] Auditory [ ] Visual
- ☐ Paranoia
- ☐ Substance Use/Abuse
- ☐ Eating Disorder or Difficulties
- ☐ Other:_____

8. Frequency of: Alcohol_____ Drugs_____

9. When did the problems begin and why did you choose to seek help?

Referred by:_____ Phone:_____

INFORMED CONSENT FOR TREATMENT

PROFESSIONAL SERVICES
POLICIES AND PROCEDURES

Confidentiality Concerns:

According to state law, confidentiality and privileged communication remain the rights of the client of psychologists, psychiatrists, licensed clinical social workers and licensed marriage, family therapists. The client, or the parents/guardians/legal caretakers, must give a signed written authorization to release any written or oral material to any other person or organization. However, there are legal **Limits of Confidentiality** which are:

1. If an individual intends to take harmful or dangerous action against another human being, or against himself/herself, it is the therapist's duty to warn the person and/or family of the person who is likely to suffer the results of harmful behavior; or the family of the client who intends to harm himself/herself of such an intention. (Tarsaoff Decision - California Courts)
2. When there is reasonable suspicion of child abuse or elder abuse the therapist, as a legal mandated reporter, is legally responsible to report such suspicion to Child Protection Agencies or Elder Protection Agencies. California state law mandates the reporting of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, and emotional and psychological abuse. All actual or suspected acts of child abuse must be reported to the appropriate agency.
3. There may be a need to release evaluation and treatment information to the referral agency and third party payer requests for information. If so, the therapist will clarify this with the client.
4. If legal proceedings are involved in which the client's mental or psychological condition is a concern the Judge may sign a subpoena for treatment records.
5. For minor children and adolescents: parents/guardians/legal caretakers have the right and responsibility to know evaluation and assessment, treatment plan, treatment concerns and overall progress, and discharge conditions. All efforts will be taken to ensure confidentiality of sessions with minors that will secure the therapeutic relationship.

Appointments and Fees:

Appointments are made on a reserved basis exclusively for each client; therefore, **a** minimum of 24 hours advance notice is required for a cancellation. The client will be charged **FULL FEE** if there is a same day cancellation or a no show. "FULL FEE" is defined as the complete fee for service rather than the regular co-pay.

All fees and co-payments are due and payable by the responsible party when professional services are rendered. The responsible party remains accountable for any charges that are not covered by insurance or other payer system; for example, telephone calls, crisis interventions.

The client or the responsible individual for the client is personally responsible for any debts incurred for services rendered. The purpose of insurance carrier coverage is to provide the client, with a partial or complete reimbursement for fees for services rendered. This reimbursement is governed by the policy covering the client. The insurance company is in no way obligated for any debt incurred for professional services rendered. The service providing the processing of client claims is not a guarantee of reimbursement by the client's insurance carrier for any claims submitted on his/her behalf. The client or the responsible individual for the client is fully responsible for this financial obligation.

Assessment, Diagnosis, and Treatment Plan Development:

The initial appointment is of the purposes of assessment, diagnosis and treatment plan development. Where appropriate, the therapist will discuss the three areas with the client. When appropriate, the client will be involved with the therapist in the formulation of the treatment plan and, at a later date, the discharge plan. One of the purposes of treatment is for the client to become increasingly responsive and responsible in his/her own life. To this purpose, the client and therapist will work together to achieve this throughout the treatment duration.

Insurance Utilization:

In utilizing insurance mental health benefits any protected health information will be used for treatment purposes which includes billing and payment for services, assessment, diagnosis, treatment plan, request for additional visits, and discharge planning and summary. The transmission of such information may include regular US Postal Service, email, voice mail, faxing, electronic billing, or other reasonable method of transmission of information.

Verbal Therapist To Client Contact:

Therapist to client contact (or therapist's office staff) for purposes of scheduling rescheduling, billing clarification, follow up regarding client cancellation or no show, or other client issues will be communicated via telephone, voice mail, email, fax, or other communication methods that the client provides as acceptable forms of contact. Reasonable precaution will be observed when leaving information with someone other than the client. Please inform the therapist if extra precautions are necessary.

Written Therapist To Client Contact:

Therapist to client written contact (or therapist's office staff contact) will be for the purposes of treatment concerns including billing concerns. Written correspondence will be sent to the client's home address unless otherwise specified by the client. Correspondence will indicate the business name and business mailing address. Please inform the therapist if extra precautions are necessary.

Client To Therapist Contact:

Clients may contact the therapist by telephone during regular business hours Monday through Friday, 9:00 am to 5:30 pm. After hours, weekends, and holidays, the therapist may be contacted by Text or Voice Mail. Reasonable client to therapist contact includes scheduling issues, clarification of a previous session (i.e. therapeutic assignment, concept/principle clarification, information giving or receiving, etc.), or a necessary immediate update with therapist feedback. Crisis calls that are not life threatening are also appropriate (i.e. recent diagnosis of a serious illness; notice of a pending death or loss of a loved one; serious change of status of self or family; or other life-changing events that necessitates therapeutic support or guidance). Immediate life-threatening circumstances must be first handled by calling 911, securing police, medical or other emergency intervention services, and securing client or family member safety. After such emergency and safety intervention services have been secured, the therapist may be contacted if necessary. All calls will be charged at the rate of $25.00 per fifteen minutes after the first fifteen minutes.`

Professional Consultation:

In order to maintain the high level of specialized professional psychotherapeutic services, the therapist may seek consultation from other licensed health care providers. This is solely for the purpose of seeking additional professional expertise, therefore, any identifying client data will not be revealed.

Acknowledgment, Acceptance, and Signature of Informed Consent:

I have read and understand the **Informed Consent Professional Services Policies and Procedures** and I accept all terms of this document. My signature indicates that I am sufficiently and in good faith informed of the treatment conditions, policies, and procedures for both the professional treatment services and the financial responsibility for such services.

I give my informed consent for Deborah A. Corona, L.M.F.T. to provide counseling and psychotherapeutic services for:

____ Myself DOB_____

_____ _____

Signature Date

TELEHEALTH INFORMED CONSENT

I _____ hereby consent to engage in Telehealth services with **DEBORAH A. CORONA, MFC18264**.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or Phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of client's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidential of my treatment information during in-person psychotherapy.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that I am responsible for using a location that is private and free from distractions or intrusions to ensure confidentiality.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree that my therapist will bill my insurance EAP plan for Telehealth and that I will be billed for any portion that is my responsibility, and I have been provided with this information in the Informed Consent Form.

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

_____ _____

Client's Signature Date

_____

Client's Printed Name

POLICY STATEMENT

APPOINTMENTS

Appointments are scheduled especially for each client for a particular day and time. A series of scheduled appointments (weekly or bi monthly) are given to secure the day and time that is needed so that therapeutic treatment continues without interruption due to unavailable hours. No one can or will be scheduled in your scheduled time. It is an inconvenience when you fail to attend your scheduled appointment. The therapist is kept waiting and another individual seeking treatment is unable to schedule for the hour that you missed. Therefore, the following will occur when a scheduled appointment is not kept:

***24 HOUR CANCELLATION POLICY*:**

1. **Scheduled appointments MUST be cancelled 24 hours in advance.**
2. **Same day cancellation will be charged full fee for the session. Full fee is defined as what your insurance pays the provider. It is not your co-pay.**
3. **Other scheduled appointments will continue to be on the calendar.**
4. **Too many or too frequent cancellations, whether 24 hours in advance or same day, is an indication that you are not able or willing to honor the treatment schedule and will result in termination of treatment.**

***NO SHOWS*:**

1. **You will be charged full fee for the session.**
2. **Full fee is defined as what your insurance pays the provider. It is not your co-pay.**
3. **You have 24 hours to call the therapist to secure any other scheduled appointments.**
4. **Not calling to indicate your intention to continue therapy will result in cancellation of other scheduled appointments.**
5. **You may return to your therapy once you have paid in full for the No Show appointment.**

WRITTEN CORRESPONDENCE

All written correspondence requires time and accuracy of thought of your treatment to construct appropriate content while protecting your confidentiality. This includes correspondence to the Court, Attorneys, Child or Adult Protective Services, Social Workers, Doctors, and other agencies or individuals. The following will be required prior to writing or sending any correspondence:

1. **A thoroughly completed and signed Authorization to Disclose Information.**
2. **A $100.00 fee is charged and is payable in cash PRIOR to writing, releasing, or sending written correspondence.**
3. **Minimum of 2 weeks advance notice required.**
4. **Requests shorter than 2 weeks advance notice will not be completed timely resulting in not meeting the necessary deadline.**

***FORMS*:**

All forms require time and accuracy of thought of your treatment to construct appropriate content while protecting your confidentiality. This includes but not limited to Disability Forms, Family Medical Leave Act (FMLA), and other agencies or individuals. The following will be required prior to completing, releasing, or sending any forms:

1. **A thoroughly completed and signed Authorization to Disclose Information.**
2. **A $75.00 fee is charged and is payable in cash PRIOR to completing, releasing, or sending forms.**
3. **Minimum of 2 weeks advance notice required.**
4. **Requests shorter than 2 weeks advance notice will not be timely completed resulting in not meeting the necessary deadline.**

***FAXING*:**

All materials requesting to be faxed require accuracy of thought of your treatment and time to construct appropriate content while protecting your confidentiality. This includes but not limited to all the previously mentioned written correspondence, forms, and other agencies or individuals. The following will be required prior to writing or sending any correspondence:

1. **A thoroughly completed and signed Authorization to Disclose Information.**
2. **A $15.00 fee is charged and is payable in cash PRIOR to faxing.**
3. **Minimum of 2 weeks advance notice required.**
4. **Requests shorter than 2 weeks advance notice will not be timely completed resulting in not meeting the necessary deadline.**

COURT CASES

Wings of Courage Family Services Counseling & Presentations, Inc. does not accept Court-related cases. Designated Court cases will not be knowingly accepted. Each case will be assessed its appropriateness if a current client begins a Court case (i.e. divorce) while in treatment.

CLIENT AGREEMENT

I acknowledge that I am in receipt of and read the above polices. I understand the policies and I agree to abide by them.

_____ _____

Client **Date**