Demographics & Consent for Services

(Adult Client)

Demographics

Date: _____

Name: _____ DOB: _____ Age: _____

Phone #: _____ Email: _____

SSN: _____-_____-_____ (required for Soonercare and Tricare Clients)

Home Address: _____

City: _____ State: _____ Zip Code: _____

Gender: Male / Female / Transgender Gender Expression: _____

Race: _____ Religious Preference: _____

Marital Status: _____

Employer/School: _____

Emergency Contact: _____ Phone: _____

Insurance Carrier: _____

Member ID / Policy #: _____

Name of Primary Policy Holder if different from client: _____

DOB of Primary Policy Holder: _____

Messages

May we leave a message? (Please check all that apply)

☐ None ☐ Yes – Client # ☐ Yes – Emergency Contact #

Referral

How did you hear about Core Counseling? _____

_____

How May We Help You?

What are the major reasons for seeking services at this time?

_____

DHS/Court

Are you currently involved with DHS or the courts or anticipate needing your psychotherapy notes now or in the future for legal reasons? Circle one: YES / NO If Yes, please explain: _____

_____

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_____ (Initial) I understand that my therapist and CC/SPTS, does not participate in legal proceedings related to client therapy. The therapist does not testify in court or provide any documentation to lawyers or court representatives. If court proceedings require therapist participation, fees apply and are due up-front. (See Notification of Policy on Legal Interaction for details.)

_____ (Initial) I understand that if I am involved in legal proceedings and legal agents are aware of my contact with CC/SPTS, the courts may subpoena records or may have my therapist give testimony. In such an event, the court would be waiving my right to confidentiality and fees will be involved. (See Notification of Policy on Legal Interaction for details.)

Psychological records are held by CC/SPTS for 7 years.

Consent for Services

_____ I have read and hereby certify that I understand the following:

I hereby voluntarily and of my own free will consent to receive counseling/psychological services provided by Core Counseling Services/ Southern Plains Treatment Services (hereafter referred to as CC/SPTS). I understand that consenting to these services does not waive my rights recognized under state and federal law.

Possible services include: individual, group, marital, or family therapy, assessment and/or consultation. As a client utilizing the services CC/SPTS, I understand that I have the right to ask any questions I may have about the process, methods, duration, and goals of my treatment and/or assessment; the right to discuss any concerns I may have about my progress in services provided; and the right to terminate services at my discretion. I acknowledge that my therapist or CC/SPTS also reserve the right to terminate services at their discretion.

I agree that, by participating in treatment, I will conduct myself in such a way as to protect myself and others from exposure to and/or transmission of any infectious or communicable disease, including but not limited to sexually transmitted diseases, COVID, and the flu.

Privacy & Confidentiality

I understand that the federal law (HIPAA), provides new privacy protections for medical records and patient rights with regard to the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that the clinic provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that the clinic has provided you with this information.

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I understand that, within certain limits, information revealed by me will be kept strictly confidential, and will not be revealed to any other person or agency without my written permission by completing a Release of Information form.

If I choose to have CC/SPTS process my sessions through my health insurance company, employee assistance program, or other health benefits program, I understand that information about my sessions will be disclosed. This information may include the nature of services, the diagnosis, the dates of services, the fees charged, and other relevant information specifically requested.

I understand that there are certain limits to confidentiality, in which it is required by law and/or professional ethics that a clinician or psychological associate reveal information to other persons or agencies, without my permission. These limits to confidentiality are as follows:

- If I threaten grave bodily harm or death to a reasonably identified person, the clinician or psychological associate is required (1) to inform appropriate legal authorities and the intended victims; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

- If I express a serious intent to grievously harm myself, it may be necessary for the clinician or psychological associate (1) to reveal information to family members and/or persons authorized to respond to such emergencies, in order to protect me from harm; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

- If my therapist has good reason to suspect that a child, elderly person, or disabled person is a victim of physical abuse, sexual abuse, or neglect, he/she is required by law to report the abuse or neglect to the Department of Human Services and/or law enforcement authorities.

- If a court of law issues a legitimate court order, the therapist may be required to provide information that is specifically described in the court order. Or, if I am being evaluated or treated by order of a court of law, the results of the evaluation or treatment ordered may be revealed to the court. Additionally, if I file a complaint or lawsuit against CC/SPTS or their staff, CC/SPTS may disclose relevant information regarding myself in order to defend itself.

- If I use psychological treatment and/or records on my behalf in a legal proceeding, the records must be made available to both parties by written consent.

- CC/SPTS is required to provide information requested by a legal guardian of a minor child, including a non-custodial parent who has maintained parental status.

- If a government agency is requesting information for health oversight activities or to prevent terrorism (Patriot Act), CC/SPTS may be required to provide it.

- If I file a worker's compensation case, CC/SPTS may be required, upon appropriate written request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed. Additional fees to compensate the therapist for their time may apply.

If any of these situations were to arise, CC/SPTS would make every effort to fully discuss it with me before taking action, and would limit disclosure to what is necessary.

CC/SPTS contracts with therapists who are engaged in academic and/or continuing education courses to further their knowledge and skills. As such, therapists may request to audio &/or video record sessions for supervisor review or have a supervisor observe in-person during sessions. All such individuals are bound by confidentiality. Tapes, tests, and other information obtained during contacts with CC/SPTS may be used for research and/or training purposes. I give consent for my individual data to be presented anonymously at professional meetings and/or published in a scientific journal.

There is a possibility that the clinician may change during the course of services.

I understand these limitations to confidentiality as outlined above.

Emergency Contact

I understand that CC/SPTS is an outpatient counseling facility. As such telephones and emails are not continuously monitored. If I am in a crisis situation, I agree to call 911 or go immediately to and emergency room for assistance.

Appointments

Appointments are generally 50 minutes in length. Session times are enforced out of respect for waiting clients and to give the therapist time to sanitize the office and prepare before the next client's arrival.

Payment is due at time of service. Cash, check, and credit card are accepted. There is a $5.00 charge for credit card use.

I understand that Core Counseling and my therapist will not send out appointment reminders and that I am responsible for remembering my scheduled appointments. My appointment time is reserved for me and cannot be filled by another client without adequate notice.

Cancellations must be made 24-hours prior to my appointment. I agree to the 24-hour cancellation policy. If I need to cancel or reschedule an appointment, it is my responsibility to notify my therapist by email, text or phone call if I will not be attending the scheduled appointment. Failure to do so will result in a "missed appointment."

If I have requested a reoccurring appointment slot with my therapist, I agree that those appointments are considered "scheduled appointments" even if they are not explicitly confirmed prior to each session and the cancellation policy applies.

I understand that I am responsible for arriving for my appointments on time and that if I am late for an appointment, my session will still end on time. If I am more than 15 minutes late for an appointment, it will be considered a "missed appointment" unless I have made other arrangements with my therapist.

Your therapist understands that occasionally emergency situations happen. If you have an emergency situation, please be mindful to contact your therapist directly as soon as possible to waive the "missed appointment" policy.

Charge for Missed Appointments

Private Insurance and Self-Pay Clients

_____ (Initials) I understand that if I do not give 24-hour notice, there will be a $50.00 "missed appointment" charge and that I have the option of leaving a card on file for these charges. If I choose not to, I agree to pay the invoice for these charges or pay the charges in person prior to my next session.

_____ (Initials) I agree to keep a card on file for missed appointment charges. If the card is rejected at the time of the charge, I understand that I will be invoiced for the missed appointment and agree to pay the charge. I give permission to Core Counseling & my therapist to automatically charge the following card any and all "missed appointment" fees.

Card Type: _____ Card Number: _____

Expiration: _____ CVC Code: _____ Zip Code: _____

_____ (Initials) I understand that more than 2 missed appointments may result in me being discharged from services.

Soonercare Clients

_____ (Initials) Soonercare prohibits providers from charging for missed appointments however, I understand that I am still responsible for giving 24-hour notice if I cannot attend a scheduled appointment. Two or more missed appointments may result in me child being discharged from services.

Additional Responsibilities

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I understand and agree that my responsibilities as a client include the following:

- Keep regular appointments and actively participate in treatment.
- Attempt any therapeutic assignments I have agreed to perform.
- Disclose to my clinician or psychological associate whenever I feel in crisis and/or suicidal, to work with them to come up with a crisis plan, and to give CC/SPTS discretion regarding needed disclosures in a crisis situation both while waiting to obtain services, and while in treatment.
- Not to come to the clinic under the influence of alcohol or other drugs. If I were to appear intoxicated, I agree to refrain from driving. Failure to do so would require CC/SPTS to make a DUI report.
- Never bring a weapon of any sort to CC/SPTS.
- Ask the clinician or psychological associate questions right away if I am uncertain about any aspect of my services or CC/SPTS policies.
- Pay the agreed upon fees as scheduled.

My signature below indicates that I have provided accurate demographics and read and understood the Consent for Services. Any questions have been answered to my satisfaction.

Client _____

Signature Date

Therapist _____

Signature Date