SUPPORT UNDERSTANDING GROWTH

Foundations Counseling Center

Client Name: _____
First Middle Last

Street Address: _____
Number Street City State Zip Code

Home Phone: _____ **Cell/Other Phone:** _____**Work:** _____

E-mail Address: (For appt. reminders and billing purposes only) _____

Date of Birth: _____ **Social Security #:** _____

Sex: (M) _____ (F) _____ **Marital Status:** Single Married Widowed Divorced

Is the client a full time student? YES NO **Is the client employed?** YES NO

School and level of education: _____ **Name of Employer:** _____

Referral Source: _____

If client is a minor (under age 21), please fill out information below: {otherwise, skip to next section (**)}

MOTHER

Name: _____

DOB: _____

Address: _____

_____

Phone: (H)_____ **(C)** _____

Education: _____

Occupation: _____

Employer: _____

FATHER

Name: _____

DOB: _____

Address: _____

_____

Telephone: (H) _____**(C)** _____

Education: _____

Occupation: _____

Employer: _____

** **PERSON RESPONSIBLE FOR CLIENT'S ACCOUNT:** _____

Relationship to Client: _____ **Phone:** _____

Address: _____

SS# _____**Date of Birth:** _____

Name of Employer: _____ **Occupation**: _____

** Person responsible for client account must provide signature on following page**

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance: _____

Policy/Member/Recipient #: _____ Group#:_____

Name of Policy Holder/Insured: _____

Relationship to Patient: _____ Insured's Date of Birth: _____

Insured's SSN: _____ Insured's Employer: _____

FINANCIAL AGREEMENT

1) **ALL PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT OR PATIENT'S GUARANTOR REGARDLESS OF INSURANCE COVERAGE.**
2) **Only primary insurance policies are accepted.**
3) **I understand that I will be responsible for all co-pays, co-insurance, and deductibles of the primary insurance at the time of my visit.**
4) **I understand that appointments not cancelled by 24-hour prior notice will be charged a no-show/same day cancellation fee of $75.00.**
5) **I understand a fee of $25.00 will be charged to me for each check returned due to any reason, such as insufficient funds.**
6) **I understand that there is a minimum charge of $15.00 for the disbursement of medical records. Charges may exceed $15.00 in the event that the cost of copies and shipping are greater than $15.00. The total charge must be paid before medical records are released.**
7) **I understand that a fee of $115.00 will be charged for the completion of forms and letters of any type. Each provider of services reserves the right to decline to complete any form or letter.**
8) **In the event of collection proceedings, I agree to pay any and all collection and/or interest fees that may be added to my account to recover monies due to my provider of service.**
9) **I understand that the charges mentioned above (items 3, 4, 5, 6, 7, 8) are not billed to the insurance company and are the sole responsibility of the patient/responsible party. I further understand that should I have any such outstanding charges to my account these charges must be paid before my next appointment will be scheduled.**
10) **I authorize the release of medical or other information necessary to process my insurance claims.**
11) **I authorize payment of all claims directly to the provider of services.**

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND AGREE TO THE GUIDELINES LISTED ABOVE.

_____ _____ _____

Signature of Patient or Responsible Party **Print Name** **Date**

PATIENT CONSENT FORM

The Notice of Privacy Practices provides information about how Foundations Counseling Center may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review the Notice before signing this Consent. The term of the Notice may change. If changed, you may obtain a revised copy by contacting asking your provider of services.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. Foundations Counseling Center is not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to the use and disclosure of protected health information about you for the purpose of treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures Foundations Counseling Center has already made in reliance from your prior consent. Foundations Counseling Center provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In summary, the patient/patient's guardian understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **Foundations Counseling Center has a Notice of Privacy Practices and the patient/patient's guardian has the opportunity to review this Notice.**
- **Foundations Counseling Center reserves the right to change the Notice of Privacy Policies.**
- **The patient/patient's guardian has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.**
- **The patient/patient's guardian has the right to file a formal grievance for any perceived violation of their patient rights or standard of care.**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.**
- **Foundations Counseling Center may condition treatment upon the execution of this Consent.**

_____ _____

Signature of Patient or Patient's Guardian **Printed Name of Patient or Patient's Guardian**

_____ _____

Relationship to Patient **Date**

_____ _____

Signature of Practice Representative **Date**

ELECTRONIC MAIL/TEXT MESSAGING COMMUNICATION INFORMED CONSENT FORM

Foundations Counseling Center and its associates (at their own discretion) may choose to communicate with their patients (or the guardians of their patients in the case of minors) regarding scheduling/rescheduling/canceling appointments only.

Conditions for the use of electronic mail (e-mail) and text messaging:

Foundations Counseling Center and its associates cannot guarantee but will use reasonable means to maintain security and the confidentiality of information transmitted and received via e-mail and text messaging. Foundations Counseling Center and its associates are not liable for improper disclosure of confidential information that is not the result of a provider's intentional misconduct. The following are the conditions to which electronic mail and/or text messaging will be used:

- **E-mail and/or text messaging will ONLY be used for the purpose of scheduling, rescheduling, and canceling appointments.**
- **Communicating via e-mail and text messaging is not appropriate for urgent or emergency situations.**
- **Foundations Counseling Center and its associates cannot guarantee that any particular e-mail and/or text message will be read and/or responded to within any particular time.**
- **All e-mails and text messages should be concise.**
- **There will be NO communication about complex and/or sensitive situations or medical information sent via e-mail or text messaging. Any such discussion must occur in person by appointment only.**
- **All e-mails and text messages will be printed and filed into the patient's medical record.**
- **Foundations Counseling Center and its associates will not forward patient's (or in the case of a minor, the legal guardian's) identifiable e-mails or text messages without the patient's (or legal guardian's in the case of a minor) written consent, except as authorized by law.**
- **Foundations Counseling Center and its associates are not liable for breaches of confidentiality caused by a patient or any third party.**
- **It is the patient's (or in the case of a minor, the legal guardian's) responsibility to follow-up and/or schedule appointments if warranted.**

Risks of electronic mail (E-mail) and text messaging communication:

The transmission of patient information by e-mail and/or texting has several risks that patients should consider prior to the use of e-mail/texting communication. These include but are not limited to the following risks:

- **Information communicated through e-mail and text messaging can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.**
- **Users of e-mail and text messaging can easily misaddress an e-mail or enter the wrong phone number for text messaging and send the information to unintended recipients.**
- **Back-up copies of e-mails and text messaging may exist even after the sender and/or recipient has deleted his or her copy.**
- **Employers and internet companies have a right to inspect e-mails sent through their servers.**
- **E-mail and text messages can be intercepted, altered, forwarded, or used without authorization or detection.**
- **Information sent via e-mail and text messaging can be used as evidence in court.**
- **Communication via e-mail and text messaging may not be secure and it is possible that a third party may breach the confidentiality of such communication.**

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail and text messaging.

____ I consent to the conditions and instructions outlined above with regards to communicating via e-mail and text messaging with Foundations Counseling Center and its associates.

____ I decline permission to communicate via e-mail or text messaging with Foundations Counseling Center and its associates.

_____	_____
Signature of Patient or Patient's Guardian	**Printed Name of Patient or Patient's Guardian**
_____	_____
Relationship to Patient	**Date**
_____	_____
Signature of Practice Representative	**Date**

SUPPORT UNDERSTANDING GROWTH

Foundations Counseling Center

Telehealth Informed Consent Form

I_____hereby consent to temporarily engaging in telehealth-based services with providers of Foundations Counseling Center (DBA for Jennifer C Moore, MSW, LCSW, Inc,) as part of my psychotherapy. I understand that "telehealth," in this context, includes the electronic practice of mental health care (i.e., psychotherapy), diagnosis, consultation, treatment, transfer of mental health data, and/or psycho-education using interactive audio, video, or data communications. _____

Initials

Additionally, I acknowledge that telehealth-based services are being offered in lieu of in-person face-to-face treatment (unless deemed clinically inappropriate by my provider) to maintain a responsible health radius during the 2020 COVID-19 pandemic. Such social distancing measures have been recommended by the Centers for Disease Control (CDC) and the World Health Organization (WHO) at this time. I understand that I will be asked to return to in office, face-to-face treatment when the CDC and/or the WHO deems it no longer necessary to limit social contact for purposes of health control. _____

Initials

I understand the following, with respect to telehealth-based services:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and/or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical/mental health information also apply to. As such, I understand that the information disclosed by me during the course of my therapy is largely confidential. However, there are exceptions to confidentiality, including but not limited, the clinician's obligation to report child, elder, and dependent adult abuse, as well as his/her obligation to report expressed threats of violence towards an ascertainable victim. Further, confidentiality is limited in situations in which my mental and/or emotional state is a topic in a legal proceeding and/or in circumstances in which I am considered to be a threat to myself.

(3) I also understand that the dissemination of any personally identifiable/confidential information from telehealth-based interaction shall not occur without my written consent. If my provider is an intern, I understand that my provider may communicate personally identifiable information, as well as clinical information, to his/her supervisor(s).

(4) Although the telehealth site used is HIPAA compliant, I understand that there are risks associated with this service modality. Risks include, but are not limited to, the possibility that the transmission of information could be disrupted or distorted by technical failures, the transmission of personal information could be interrupted/obtained by unauthorized persons, and/or the electronic storage of personal information could be accessed by unauthorized persons. I understand that these risks remain, despite reasonable efforts on the part of my provider and Foundations Counseling Center.

(5) In addition, I understand that telehealth-based care may not be as comprehensive as in-person face-to-face services. There are potential risks and benefits associated with any form of psychotherapy, and despite my efforts, the efforts of my provider, and the efforts of Foundations Counseling Center, my condition may not improve. I may benefit from telehealth, but results cannot be assured. I also understand that if my provider believes I would be better served by more intensive or alternative services, she/he/she and will discuss those with me.

(6) I further understand that insurance plans have informed Foundations Counseling Center that telehealth services are temporarily a covered benefit. However, benefits quoted by insurance companies are never a guarantee of the way benefits are paid. I understand that I am ultimately responsible for the payment of services regardless of insurance coverage.

(7) I understand that I have a right to access my medical information and copies of medical records in accordance with Nevada law.

(8) I understand that the consent form(s)/new patient paperwork that I completed at the initiation of therapeutic services with Foundations Counseling Center still applies, in full, for telehealth-based services. I understand that I may request a copy of the documents from the front desk at any time.

I have read and understand the information provided above. I have discussed it with my provider, and all my questions have been answered to my satisfaction.

_____ _____

Signature of patient/parent/guardian | If signed by other than patient, indicate relationship

_____ _____

Date | Signature of Clinician Date