HRA PSYCHOLOGICAL SERVICES

Counseling Intake

HRA Staff Only
HRA Staff Initials: _____ Intake Date: _____ Provider: _____
Appt Date/Time: _____ Testing Date/Time: _____

Name of person requesting the appointment: _____

Client Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Age: _____ DOB: _____ Gender: □Male □Female □Other: _____

Phone: _____ Email: _____

How did you hear about clinician / HRA?
□HRA Website □Insurance Provider □Psychology Today □Personal Referral: _____

In general terms, the focus of treatment:

_____

_____

Which clinician are you interested in seeing (if any)?: _____

Insurance Information
Would you like us to bill your insurance? □Yes □No (*If yes,please fill out info below.*)
Carrier: _____ Policy Holder: _____
DOB: _____ ID#:_____ Group#: _____
Have you called your insurance company for authorization? □Yes □No □Not Required

For Minor Clients Only
Mother's Name: _____ Father's Name: _____
Parent's Status: □Married □Divorced □Separated □Single □Widowed □Other: _____
Are both parents aware that treatment has been requested? □Yes □No □Not Sure

Consent for Payment

I hereby authorize payment of medical benefits through my insurance policy to HRA Psychological Services. I have listed all health plans from which I may receive benefits. I hereby accept responsibility for payment for any services provided to me that are not covered by my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for any missed appointment/late cancellation fees, NSF check fees, and a $10.00 charge per month on all overdue balances (past 60 days).

I hereby authorize HRA Psychological Services to use and/or disclose my health information which specifically identifies me or that can reasonably be used to identify me to carry out my treatment, payment, and health care operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, HRA Psychological Services can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions taken by HRA Psychological Services prior to receipt of my revocation.

You can review HRA's full financial policies at: hrapsychservices.com/doc/hra-financialpolicies.pdf

_____ _____

Signature of Patient or Patient's Representative Date

_____

Name of Patient (Print)

_____

Relationship of Representative to Patient

HRA PSYCHOLOGICAL SERVICES

SIGNATURE FORM FOR
ACKNOWLEDGING RECEIPT OF NOTICE OF PRIVACY RIGHTS

PLEASE READ AND REVIEW OUR HEALTH PRIVACY POLICIES HERE:
hrapsychservices.com/doc/hra-hipaa-rights.pdf

MY SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED THE **NOTICE OF HRA PSYCHOLOGICAL SERVICES POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF PATIENT HEALTH INFORMATION** AS REQUIRED BY LAW.

_____ _____
signature of patient date

OR

_____ _____ _____
signature of patient representative relationship date

_____ _____
witness date

HRA PSYCHOLOGICAL SERVICES

Consent for In-Person Services During the COVID-19 Public Health Crisis

This document contains important information about our mutual decision to engage in in-person services in the light of the COVID-19 public health crisis. **By signing this document, you are indicating that you understand and accept the risks of exposure to the coronavirus.**

Your options for receiving psychological services

You have the option to receive psychological therapy and consultation services via an **online video format or by telephone**. (Some forms of psychological evaluation and testing may not be possible without in-person contact.) If we reach a mutual agreement to engage in-person services, we both agree to follow the procedures outlined below to minimize our risks of exposure and illness. If there is a resurgence of the pandemic, or if the State changes social distancing requirements, I may determine to discontinue offering in-person services. At any point that you wish to return to telehealth services, I will respect that decision as long as it is feasible and clinically appropriate. Please note that reimbursement for telehealth services is determined by insurance companies; we can discuss that as it applies.

Our Commitment to Minimize Exposure to Coronavirus

Our office has taken steps to reduce the risk of exposure to the coronavirus within the office. These steps include: the waiting room contains hand sanitizers; physical contact is prohibited; all items, furniture and surfaces that are commonly touched are sanitized regularly; appointment times are staggered to reduce the number of people in the waiting room. If someone in our office tests positive for COVID-19, we will let you know.

Your Responsibility to Minimize Your Exposure and Ours

You understand that we are trying to reduce the possibility that you, us, or our families are exposed to an illness-causing highly contagious virus. You agree to take the following precautions in order to receive in-person services:

1. You will only keep your appointment if you are symptom free. If you or anyone in your household is sick or tests positive for COVID-19, you will let us know and you will not attend an in-person appointment.
2. You will adhere to the safe distancing precautions that we have established in our office suite.
3. You will keep a six foot distance from others and you will not engage in physical contact.
4. You will not enter our office more than 10 minutes before your appointment.
5. If you are bringing a child, you will make sure that the child follows all of these sanitation and distancing guidelines.

6. If you have a job or engage in other activities that expose you to other people who are infected, you will immediately let us know.

Your Confidentiality in the Case of Infection

Please note that if you have tested positive for the coronavirus, the State or local authorities may require that we notify them that you have been in the office. If this occurs, we will provide only the minimum necessary information necessary for their data collection and will not go into any details about the reason for our meetings. By signing this form, you agree to allow this disclosure without an additional signed release.

Informed Consent

I agree to accept the risks associated with in-person psychological services during the COVID-19 Public Health Crisis, and I agree to the policy and guidelines described above.

_____	_____	_____
Printed Name	Signature	Date

HRA PSYCHOLOGICAL SERVICES

Teletherapy Informed Consent

I hereby consent to engaging in online counseling services through HRA Psychological Services. I understand that online counseling services include, but are not limited to, consultation, treatment, and using interactive audio, video, or data communications. I understand that online counseling services involve the communication of my medical/mental information, both orally and visually, to health care practitioners that may be located outside my local area or state.

I understand that I have the following rights and responsibilities with respect to online counseling services:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. I need to be physically present, at the time of service, in a state in which my therapist holds a professional license.

3. The laws that protect the confidentiality of my medical information also apply to online counseling services. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; expressed intent to harm myself, and where I make my mental or emotional state an issue in a legal proceeding.

4. I also understand that the dissemination of any personally identifiable images or information from the online counseling services to researchers or other entities shall not occur without my written consent.

5. I understand that there are risks and consequences from these services, including, but not limited to, the possibility, despite reasonable efforts on the part of my counselor, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

6. In addition, I understand that online counseling services may not be as complete as face-to-face services. I also understand that if the counselor believes I would be better served by another form of counseling services (e.g. face-to-face services) I may be referred to a counselor who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of counseling services, and that despite my efforts and the efforts of the counselor, my condition may not be improve, and in some cases may even get worse.

7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

8. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

9. I understand that I may benefit from online counseling services, but that results cannot be guaranteed or assured.

10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read and understand the information provided above.

_____ _____

Client (or Guardian's) Signature Date

_____

Printed Name