R. E. A. L.  Counseling, LLC

The Past is Determined — The Future is Your Decision

Initial Information

Highlighted areas MUST be completed

Today's date: _____

A. Identification

Client name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ SSN#: _____ Gender: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ E-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions:

_____

Please be advised that all correspondence via text/email is not protected by HIPAA

As a courtesy, we have the ability to send out reminders for your upcoming appointments. Please complete the information below if you would like to be reminded of your schedule appointment.

Text Number: _____ Service carrier: _____ (Verizon, AT&T…)

Email: _____ Notified _____ day(s) prior to appointment

B. Referral:

How did you hear about us? _____

Medical: Clinic/doctor's name: _____

Phone: _____ Fax: (if known) _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?

☐ Yes ☐ No

C. Emergency Information:

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

Contact info: _____ Any other identifying info: _____

D. Therapy:

Please describe the main difficulty that has brought you to see me:

_____

_____

_____

E. Financial Information:

Financially responsible: _____ Relationship to Client: _____

Employer/Occupation: _____ Email: _____

Contact info is same as client ☐ Yes ☐ No If no, please complete additional contact info:

Address: _____ Phone: _____

Primary Insurance Company

Name of company: _____

Name of policyholder (if not the patient): _____ Birth Date: ____/____/____

Policy #: _____ Phone: _____

☐ ***I do not have Secondary Insurance***

Secondary Insurance Company

Name of company: _____

Name of policyholder (if not the patient): _____ Birth Date: ___/___/_____

Policy #: _____ Phone: _____

Our Agreement

I give this office permission to release any necessary information obtained during examinations or treatment of this patient to support any insurance claims on this account or to secure timely payments due to the assignee or myself.

I understand that I am responsible for all charges for services provided.

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to R.E.A.L. COUNSELING, LLC

Signature of client (parent/guardian/policy holder): _____

Printed name: _____ Date: _____

I chose NOT to file my counseling services with my insurance plan and would like to discuss further payment options. I agree to pay in full on the day services were rendered.

Signature: _____ Date: _____

If you do not have insurance, how do you plan to pay for your services from R.E.A.L. Counseling, LLC? _____

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Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Professional Disclosure Statement," "Notice of Privacy Practices" and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 business day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑Copy kept by therapist

R. E. A. L.  ***Counseling, LLC***

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PERMISSION TO CONTACT

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____ , hereby acknowledge that R.E.A.L. Counseling, LLC has either offered me or provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact: R.E.A.L. Counseling, LLC, PO Box 31447, Myrtle Beach, SC 29588/Phone: 843.273.0077/Fax: 843.273.0075/Email: info@realcounselingllc.com

I also understand that I am entitled to receive updates upon request if R.E.A.L. Counseling, LLC amends or changes the Notice of Privacy Practices in a material way.

_____ _____

Signature — Relationship to Patient, if signed by someone other than patient

It may occasionally be useful or necessary to send you information by mail, email and/or text. If you believe that this would compromise your privacy or safety, you have the right to deny permission and request an alternate form of communication, such as phone contact. If your circumstances change, you can revoke permission to receive mail at any time.

WE DO EVERYTHING POSSIBLE TO PROTECT YOUR INFORMATION, PLEASE UNDERSTAND THAT ALL ELECTRONIC CONTACT VIA EMAIL AND/OR TEXT CANNOT BE PROTECTED BY HIPPA

I give permission for **R.E.A.L. Counseling, LLC** to send written communication to me related to my services. This is not to include emergencies and/or direct therapeutic interactions. I understand that I may withdraw this permission at any time.

Preferred Mailing Address: _____

I consent to contact via email and prefer this email to be used _____ _____

I consent to text messages and prefer this number to used _____ _____

Cell Phone Carrier: _____ (Verizon, Sprint, AT&T…)

_____ _____

Signature — Printed Name:

R.E.A.L.  Counseling, LLC

Authorization to Release Medical Records

Patient's Name:	**DOB:**
Patient's Current Address:	
Patient's Previous Address:	
Patient's Current Phone #:	

INFORMATION TO BE RELEASED

☐ **All Records**

☐ Other, (specify): _____

REASON FOR REQUEST

☐ **Personal Records** ☐ **Specialist/Referral** ☐ **School** ☐ **Insurance** ☐ **Legal**

☐ **Transferring Out**

Transferring Reason: ☐ **Relocation** ☐ **Change Insurance** ☐ **Unhappy with Staff/Practice**

☐ **Other:** _____

DELIVERY OF RECORDS

☐ **Pick Up In Person** ☐ **Via Regular Mail** ☐ **Fax :(___)** _____

RELEASE INFORMATION TO

NAME:

ADDRESS:

CITY: **STATE:** **ZIP:**

*****By signing below, I understand that (1) I release REAL Counseling, LLC and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damage, which may result from the release of information authorized by this Consent for Release of Medical Information; (2) this consent is valid from the date signed and continues until I revoke this authorization by giving R.E.A.L Counseling, LLC written notice; (3) I may revoke this authorization at any time, unless the action has already been taken utilizing this signed consent or it the authorization was obtained as a condition of obtaining insurance coverage; (4) the practice will not condition treatment or payment based on my signing this authorization; (5) I am signing this authorization freely; (6) no one has pressured me to sigh this authorization; (7) I acknowledge that I've had an opportunity to review this authorization and understand the intent and use; (8) the information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.**

_____ _____ _____

CLIENT OR PARENT/LEGAL GUARDIAN SIGNATURE Relationship to client Date

R.E.A.L Counseling, LLC

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AND/OR YOUR CHILD(REN) [AS A PATIENT OF THIS PRACTICE] MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR AND/OR YOUR CHILD(REN) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. Our Commitment to You and/or your [Child(ren)] Privacy

Our practice is dedicated to maintaining the privacy of you and/or your child(ren) individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and/or your child(ren) and the treatment and services we provide to you and/or your child(ren). We are required by law to maintain the confidentiality of health information that identifies you and/or your child(ren). We also are required by law to provide you with this notice of our legal duties and the privacy practice that we maintain in our practice concerning you and/or your child(ren) IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose you and/or your child(ren) IIHI
- You and/or your child(ren) privacy rights in you and/or your child(ren) IIHI
- Our obligations concerning the use and disclosure of you and/or your child(ren) IIHI

The terms of this notice apply to all records containing you and/or your child(ren) IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintain in the past, and for any of you and/or your child(ren) records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

B. We may use and disclose you and/or your child(ren) IIHI in the following ways:

1. **Treatment:** Our practice may use you and/or your child(ren) IIHI to treat you and/or your child(ren).
2. **Payment:** our practice may use and disclose you and/or your child(ren) IIHI in order to bill and collect payment for the services and items you and/or your child(ren) may receive from us. For example, we may contact your health insurer to certify that you and/or your child(ren) are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding you and/or your child(ren) treatment to determine if your insurer will cover, or pay for, you and/or your child(ren) treatment. We also may use and disclose you and/or your child(ren) IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use you and/or your child(ren) IIHI to bill you directly for services and items.
3. **Appointment Reminders:** Our practice may use and disclose you and/or your child(ren) IIHI to contact you and remind you of an appointment. We may leave a message on your answering machine, email about you and/or your child(ren) appointment, which ever you authorize.
4. **Disclosure Required by Law:** Our practice will use and disclose your child(ren) IIHI when we are required to do so by federal, state or local law.

C. - Use and disclosure of your IIHI in certain special circumstances.
The following categories describe unique scenarios in which we may use or disclose your IIHI:

1. **Public Health Risk:** Our practice may disclose you and/or your child(ren) IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contacting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding potential abuse or neglect of an adult/ child(ren) patient (including domestic violence): however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

2. **Lawsuits and Similar Proceedings:** Our practice may use and disclose you and/or your child(ren) IIHI in response to a court or administrative order, if you and/or your child(ren) are involved in a lawsuit or similar proceeding. We also may disclose you and/or your child (ren) IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

3. **Law Enforcement:** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our office, including returned checks (nono sufficient funds)
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or description, identity or location of the perpetrator)
4. **Serious Threats To Health or Safety:** Our practice may use and disclose you and/or your child(ren) IIHI when necessary to reduce or prevent a serious threat to you and/or your child(ren) health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the treat.

Notice of Privacy Practice

D. Your Rights Regarding your IIHI

1. **Confidential communications:** You have the right to request that our practice communicate with you about you and/or your child (ren) health and related issued in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, **you must make a written request to Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable request. You do not need to give a reason for your request.
2. **Requesting restrictions:** You have the right to request a restriction in our use or disclosure of your child(ren) IHII for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your child(ren)IIHI to only certain individuals involved in your child(ren) care or the payment for your child(ren) care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat your child(ren). In order to request a restriction in our use or disclosure of your child(ren) IIHI, **you must make your request in writing to Privacy Officer: PO Box 31447, Myrtle Beach, SC 29588.** Your request must describe in a clear and concisefashion:
    a. The information you wishrestricted
    b. Whether you are requesting to limit our practice's use, disclosure or both
    c. To whom you want the limits toapply
3. **Inspection and copies:** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you and/or your child(ren), including patient medical records and billing records, but not including psychotherapy notes. **You must submit your request in writing to Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077** in order to inspect and/or obtain a copy of you and/or your child(ren) IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment:** You may ask us to amend you and/or your child(ren) IIHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, **your request must be made in writing and submitted to Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077.** You must provide us with a reason that supports your request for amendment. **Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing.** Also, we may deny your request if you ask us to amend information that is in our opinion; (a) accurate and complete, (b) not part of the IIHI kept by or for the practice, (c) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of disclosures:** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of you and/or your child (ren) IIHI for non-treatment, non-payment or non-operations purposes. The use of you and/or your child(ren) IIHI as part of the routine patient care in our practice is not required to be documented. For example, the provider shares information with the clinical staff, or billing department using your information to file you and/or your child(ren) insurance claim. In order to obtain an accounting of disclosures**, you must submit your request to Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077**. **All requests for an "accounting of disclosures" must state a time period, which may not be longer than 6 (six) years from the date of disclosure and may not include dates before October 2010.** The first list you request within a 12-monht period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before your incur any costs.
6. **Right to a paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact the **Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077**
7. **Right to File a Complaint:** If you believe you and/or your child(ren) privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice**,** contact the **Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077. All complaints must be submitted in writing. <u>You will not be penalized for filing acomplaint</u>**.
8. **Right to Provide an Authorization for Other Uses and Disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you and/or your child(ren) IIHI may be revoked at any time in **<u>writing</u>**. After you revoke your authorization, we will no longer use or disclose you and/or your child(ren) IIHI for the reasons described in the authorization. Please note we are required to retain records of you and/or your child(ren)care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the **Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077**

Tele-mental Health Informed Consent for R.E.A.L. COUNSELING, LLC

I, _____ (name of client) hereby consent to participate in tele-mental health with _____ (name of provider) as part of my psychotherapy. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to tele-health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

3) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

4) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate and a higher level of care is required.

5) I understand that I am responsible for: a) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, b) ensuring security on my computer, and c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

In case of an emergency I will need you to agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency this is my location: _____

My emergency contact-

Name: _____ Relationship to client: _____ Phone: _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Patient Name:	DOB:	DOS:

Interventions/Actions/Goals

CPT Code	Description	Units	Frequency	Duration

Additional Comments:

Patient Signature: _____

Provider Signature: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?						
	2. Feeling down, depressed, or hopeless?						
II.	3. Feeling more irritated, grouchy, or angry than usual?						
III.	4. Sleeping less than usual, but still have a lot of energy?						
	5. Starting lots more projects than usual or doing more risky things than usual?						
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?						
	7. Feeling panic or being frightened?						
	8. Avoiding situations that make you anxious?						
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?						
	10. Feeling that your illnesses are not being taken seriously enough?						
VI.	11. Thoughts of actually hurting yourself?						
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?						
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?						
VIII.	14. Problems with sleep that affected your sleep quality over all?						
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?						
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?						
	17. Feeling driven to perform certain behaviors or mental acts over and over again?						
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?						
XII.	19. Not knowing who you really are or what you want out of life?						
	20. Not feeling close to other people or enjoying your relationships with them?						
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?						
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?						
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?						