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SIGNATURE PACKET FOR CLIENT WITH GUARDIAN(S)

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Thank you for choosing Spectra for your child's behavioral health needs! This packet includes the consent forms that require your signature so your child can receive services from us. Please note that if you are the insurance subscriber for your child and/or you are responsible for payments related to his/her healthcare then we require you to complete the form "Responsible Party Acknowledgement of Agency Policies" Our intake coordinator Karen Weiss, LSW is available to provide you with further information and may be contacted by email at karen@spectrapa.com or by phone 484-450-6476, ext. 710.

Revision Date: 2/3/18

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INTAKE FORM FOR CLIENT WITH GUARDIAN(S)

Name of Client:	
Name of person completing this form:	Relationship to Client:
Client's date of Birth:	Client's Age:
Address:	
Languages:	Email:
Client lives with:	
Client's Occupation or School & Grade:	
History of psychiatric treatment or counseling:	
Current or past drug or alcohol use:	
Significant medical problems:	
Serious illnesses, accidents, surgeries, or hospitalizations in the past:	
Medications currently prescribed:	
Primary Care Physician:	Phone of PCP:
Psychiatrist:	Phone of Psychiatrist:

Main Contact name for client with guardian(s):		
Address:		
Home Phone:	Work Phone:	Mobile Phone:
Does this Main Contact live with the client?		
Please check all that apply: ❑ Parent ❑ Adult Child ❑ Sibling ❑ Spouse ❑ Emergency Contact ❑ Other: _____		
Secondary Contact name for client with guardians (if applicable):		
Address:		
Home Phone:	Work Phone:	Mobile Phone:
Does this Secondary Contact live with the client?		
Please check all that apply: ❑ Parent ❑ Adult Child ❑ Sibling ❑ Spouse ❑ Emergency Contact ❑ Other: _____		
Name of Biological Mother:	Name of Biological Father:	
Name of Additional Parent(s): Step-Mother:	 Step-Father:	
Other adults who live with client:		

Select the statements that reflect the client's current life situation (choose all that apply):

- ☐ Client has two legal guardians
- ☐ Client has one legal guardian
- ☐ Client's biological parents are married
- ☐ Client's biological parents are divorced or were never married
- ☐ Client has adoptive parents
- ☐ Client lives with both legal guardians
- ☐ Client lives with one legal guardian
- ☐ Client lives with/in (please specify)_____

For Parents who are divorced or were never married, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)

Is ex-spouse (biological parent) aware that you are bringing the client to Spectra for treatment?

❑ Yes ❑ No

If no, please describe:

If adopted, does client know of adoption? ❑ Yes ❑ No

What age was the client at the time of the adoption?

Are there any other agencies involved with the family (DCFS, Client Welfare, Courts, etc.)?

❑ Yes ❑ No

If yes, please describe:

History of Problem

Please describe what concerns you have regarding the client:

How long has the problem existed?

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

What attempts have been made to resolve the difficulties?

Please check the symptoms that the client and any family member(s) are currently experiencing. Please indicate to which family member you are referring, as well as duration, and severity.

Symptom	**Who?**	**How Long?**	**Severity:** None 0	Mild 1	Moderate 2	Severe 3
Sadness or Depression						
Suicidal Thoughts						
Sleep Problems						
Changes in Appetite						
Weight Change						
Inability to Concentrate						
Obsessive Thoughts						
Tension and Anxiety						
Panic Attacks						
Memory Problems						
Compulsive Behaviors						
Feelings of Hostility						
Acts of Violence						
Social Isolation						
Strange Thoughts						
Stomach Aches						
Head Aches						
Bed Wetting						
Phobias						

Print Client Name: **Client's Date of Birth:**

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF POLICIES AND PRIVACY PRACTICES

We at Spectra Support Services, LLC are required by law to maintain the privacy of and to provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer, Patricia Gonzalez, LPC, in person or by phone at 484-450-6476, ext. 701. If you would like an additional copy of the Notice, at any time, please ask. You may also view the "Notice of Policies and Privacy Practices" on our website.

Please understand that all records, written information, or any electronic data are marked **CONFIDENTIAL**. Client records are maintained with on-line electronic medical record companies that assure HIPAA compliance: Therap Services, LLC, or TherapyNotes. Spectra Support Services, LLC conducts business operations on G-Suite which is a security certified online service. Spectra Support Services, LLC maintains a "Business Associate Agreement" (BAA) to use G-Suite in order to meet HIPAA compliance standards. Our staff are trained on how to practice HIPAA compliance while using online services.

All sessions, including telephone or email contacts are confidential to persons outside of the sessions with some exceptions. Therapists on staff at Spectra may share information with other staff members at Spectra for the purposes of supervision, case coordination, or case consultation.

Your therapist is required by law to report:

- threats of harm to another or oneself.
- domestic violence.
- child or elder abuse.
- when directed by the court.
- per a client or parent/legal guardian's signed release.

Please know you always have the right to ask questions of your therapist(s). Therapy only works if you have trust and confidence in us and feel our care and concern for you.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

Signature of Client/ Legally Authorized Representative Date Relationship to Client

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Print Client Name: **Client's Date of Birth:**

INFORMED CONSENT FORM

Informed Consent Statement for Treatment for the Client named above.

Select the statement that applies to your life situation:

- ❑ I attest that I am an adult 18 years of age or older.
- ❑ I attest that I am a juvenile that is at least 14 years of age and under the age 18.
- ❑ I attest that I am the biological parent of the client named above and I am married to the client's other biological parent.
- ❑ I attest that I have full legal custody or guardianship of the client named above and am legally authorized to initiate and consent to treatment on behalf of this individual without the consent of additional parties*. I will produce legal documentation of such upon request.

  **In the state of PA, if both parents/guardians of a child are married, only one parent/guardian is needed for consent. In the event that parents are divorced or were never married, both biological parents/guardians must consent unless a custody/guardianship document from a court of law states otherwise.*

- ❑ I attest that I have joint legal custody of the client named above and I authorize consent to treatment on behalf of this individual. I understand that in the state of PA both parties are required to consent to treatment on behalf of this individual.

Client or Legal Guardian:

I agree and consent to my/the above client's participation in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the client. I understand that with my written consent and if therapeutically appropriate, Spectra therapists may involve other adults/caregivers in the therapeutic process whether or not they have legal custody at the time of service.

My signature below represents my consent, agreement, and understanding.

Signature of Client/Legally Authorized Representative Date

Print Client Name: **Client's Date of Birth:**

INFORMED CONSENT FORM - CONTINUED

Client's Representative:
I understand that the client named above has the legal authority to consent to said client's own treatment. I attest that I am the designated representative who advocates for the client's best interests and supports the client in the process of making informed decisions related to treatment and services. My signature below represents my agreement with the client's decision to participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider.

Signature of Client's Representative (if applicable) Date Relationship to Client

Client Representative's Address & Phone

Spectra Staff:

I, the designated Spectra staff person, have discussed the issues above with the client and/or the parent, guardian, or representative. My observations of this person's behavior and responses give me reason to believe that this person **is fully competent** to give informed and willing consent.

Signature of Spectra Staff Person Date Job Title

Or

I, the designated Spectra staff person, have discussed the issues above with the client and/or the parent, guardian, or representative. My observations of this person's behavior and responses give me reason to believe that this person **may not have competency** to give informed and willing consent.

Signature of Spectra Staff Person Date Job Title

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Print Client Name: _____ **Client's Date of Birth:** _____

GENERAL CONSENT TO RELEASE INFORMATION

IMPORTANT: Please indicate your selections by writing your initials.

CONSENT FOR RELEASE OF INFORMATION TO INSURANCE PLAN AND ASSIGNMENT OF BENEFITS:
SELECT ALL THAT APPLY TO THE SERVICES YOU RECEIVE

_____ **Initial if you/the client receives therapy from a licensed clinician and you are assigning insurance benefits to Spectra.**
I give consent to Spectra Support Services LLC to release medical information to my/the client's insurance company/companies. I certify that the information I have reported with regard to my insurance coverage is correct. I give consent for the release of any necessary medical information for this or any related claims, in writing (i.e. treatment plans) or verbally (i.e. requesting benefit/authorization information by phone). I agree with the assignment of my insurance benefits to Spectra Support Services LLC. I permit a copy of this consent to be used in place of the original. This consent may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. If my insurance company limits visits, I accept responsibility for monitoring the number of allowed sessions used. I agree to pay for all non-covered services, including late cancellations/missed appointments, telephone appointments, services provide after benefit exhaustion, and services determined not to be necessary by my insurance carrier.

Complete the following if you are assigning your insurance benefits to Spectra Support Services LLC.

Primary Insurance Carrier	Member Number (s)	State/Group
Secondary Insurance Carrier	Member Number (s)	State/Group

_____ **Initial if you/the client receives therapy from a licensed clinician and insurance benefits will not be assigned to Spectra.**
I <u>DO NOT</u> give consent to Spectra Support Services LLC to apply for benefits or to release medical information to my/the client's insurance company/companies. **<u>I accept responsibility for full payment of all services provided according to the private pay fee schedule.</u>** I agree to pay for all out-of-network or non-covered services including later cancellations, missed appointments, telephone appointments. I understand that my benefits will be absent because no information will be released to my insurance carrier.

_____ **Initial if you/the client receives therapy from a pre-licensed clinician or services are not reimbursable by insurance.**
I acknowledge that I have chosen services from a pre-licensed clinician or services that are not reimbursable by my insurance. I accept responsibility for payment of all services provided at the agreed-upon rate. I acknowledge that insurance does not reimburse clinicians without a clinical license or certain services that are not deemed medically necessary. I agree to pay for services including late cancellations, missed appointments, and telephone appointments.

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Print Client Name: **Client's Date of Birth:**

General Consent to Release Information - Continued

CONSENT FOR RELEASE OF INFORMATION FOR HEALTHCARE OPERATIONS:

☐ I give consent to Spectra Support Services LLC to share necessary health information with staff that the agency may hire or contract with as well as software support to assist with billing, scheduling, or other office operations

CONSENT FOR RELEASE OF INFORMATION FOR PURPOSES OF CLINICAL SUPERVISION

☐ I give consent to Spectra Support Services LLC to share necessary health information with other Clinical Staff members within the agency for purposes of clinical supervision and effective treatment. I recognize that as little information will be provided as is necessary.

POLICY FOR RELEASE OF INFORMATION IN SPECIAL SITUATIONS:

☐ I understand that Spectra Support Services LLC may disclose health information about me in the event of a serious threat to the health and safety of myself or others, in the event of suspected child abuse or neglect, or in other situations as detailed in the Notice or Privacy Practices.

CONSENT FOR RELEASE OF INFORMATION FOR APPOINTMENT REMINDERS OR SERVICES:

For the purposes of appointment reminders and or setting up future appointments:
Please indicate your selections by writing your initials on the line.

☐ I authorize Spectra Support Services LLC to contact me by phone at _____.

☐ I authorize Spectra Support Services LLC to contact me by text at _____.

☐ I authorize Spectra Support Services LLC to leave a message on voice mail at _____.

☐ I authorize Spectra Support Services LLC to contact me by email at _____.

☐ I authorize Spectra Support Services LLC to email me billing statements to the above email address.

☐ I authorize Spectra Support Services LLC to give me appointment reminders to my email.

My signature below represents my consent, agreement, and understanding.

Signature of Client/ Legally Authorized Representative Date Relationship to Client

Print Client Name: **Client's Date of Birth:**

RESPONSIBLE PARTY ACKNOWLEDGEMENT OF AGENCY POLICIES

Payment Responsibility: I, _____ am financially responsible for the services provided to the client named above.

- My insurance benefits and my co-pays/ charges for services have been explained to me.
- I agree to make payment of all copays/charges **at the time of service**. Payments may be cash or check or credit.
- I acknowledge receipt of the fee schedule and information regarding my insurance coverage (if applicable).
- Cancellation policy: I agree to inform the therapist by voice (to 484-450-6476, extension 2) in the event that I/ the client will not be available with as much notice as possible.
  - **Sessions cancelled with less than 24 hours' notice will be charged a $35.00 fee, no matter the circumstances.**
  - *A client who uses Medical Assistance to pay for a service is not subject to the cancellation fee. However, if the client fails to cancel a total of 3 sessions without sufficient notice can be grounds for immediate termination of services.*
- I understand that in group experiences, there is **no credit for cancelled sessions**. However, the Director may (at her discretion) offer a credit for future individual or group sessions if the client is unable to complete the current session because of extenuating circumstances.
- **Cases of custody disputes:** I acknowledge that Spectra provides therapy in a contextual family framework that affirms the need for children to have contact with family members and to involve them in therapy to the greatest extent possible. To that end, Spectra therapists will not accept voluntary requests to testify on behalf of one parent against another or prepare documents for use in court.
- **Acknowledgement of credentials:** I acknowledge that I have read the therapist's credentials, as described in printed form.
- **Acknowledgement of client rights:** I acknowledge that I have read the Spectra Client Rights and Responsibilities which include my right to file a grievance and been made aware of the on-site location of the more extensive Policy and Procedure Manual for Spectra Support Services, LLC. If applicable, I acknowledge receipt of the following supplemental forms, as required by my insurance carrier: _____.
- **Acknowledgement of Urgent Care/Crisis Intervention Policy:** I acknowledge receipt of the Urgent Care/Crisis Intervention Policy, contact information for the urgent care line, and resources for mental health emergencies.
- **Policy for termination:** I acknowledge that it is my choice to participate/ to have my client participate in therapy services. If I decide to terminate treatment, I will discuss termination before ending treatment so that a proper transition and discharge plan may be developed.

Before you sign below, please ask any questions you may have of this document.

My signature below represents acknowledgment and understanding.

Signature of Client/ Legally Authorized Representative Date Relationship to Client

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Print Client Name: _____ **Client's Date of Birth:** _____

CONSENT TO TREATMENT FOR JUVENILES

COMPLETE THIS CONSENT ONLY IF YOU ARE A JUVENILE: If you are at least 14 years of age and under age 18 in the state of PA, you are considered a juvenile, and may consent to your own mental health examination and treatment. You do not need a parent or guardian's permission to participate in these services. Also, a parent or legal guardian may provide consent for you to receive mental health services without your consent. In either situation, the non-consenting person cannot override the consent of the other person. To learn more about mental health treatment for juveniles in PA **CLICK HERE**. **Please make your selection below after you reviewed this document and/or had a discussion with your therapist.**

JUVENILE CLIENT

(14 years of age and under 18)

- ❑ I, _____ (client), **agree and consent** to participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider.
- ❑ I, _____ (client), **DO NOT agree and consent** to participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider.

Client's Signature _____ Date _____

PARENT/GUARDIAN

- ❑ I, _____ (guardian/parent), **agree and consent** to have my child participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider.
- ❑ I, _____ (guardian/parent), **DO NOT agree and consent** to have my child participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider. I realize that, by law, my juvenile may continue services without my consent.

Parent/Guardian's Signature _____ Date _____

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Print Client Name: **Client's Date of Birth:**

CONSENT TO TREATMENT FOR JUVENILES - CONTINUED

THERAPIST

- ❑ I, the designated Spectra staff person, have discussed the issues related to treatment with the client and/or parent/guardian. My observations of the responses from the client and parent/guardian give me reason to believe that they are **fully competent** to give informed and willing consent.

- ❑ I, the designated Spectra staff person, have discussed the issues related to treatment with the client and/or the parent, guardian, or representative. My observations of the responses from the client and parent/guardian give me reason to believe that this person **may not have competency** to give informed and willing consent.

Signature of Spectra Staff Person Date Job Title

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Client: **DOB:** **Clinician(s):**

PHOTOGRAPHY, VIDEO, AUDIO, AND PROTECTED HEALTH INFORMATION (PHI) INTERNAL AUTHORIZATION AND RELEASE

1. I, (print name) _____, on behalf of the client named above, hereby authorize Spectra Support Services, LLC to USE and DISCLOSE the protected health information listed in #2 below.

2. I authorize disclosure of the PHI information to the following persons/organizations/situations. **(Check all that apply)**:
   - ❑ Photography/Video/Audio will be recorded and disclosed to client's assigned clinician(s) **for documentation purposes**.
   - ❑ Photography/Video/Audio will be recorded and disclosed to Spectra Support Services, LLC **for supervision purposes**.
   - ❑ Photography /Video/Audio will be recorded and disclosed to Spectra Support Services, LLC for internal use for the purposes of **creating art or musical works.**
   - ❑ Other: _____

3. This authorization will expire:
   - ❑ After termination of therapy services with the specified clinician(s) above.
   - ❑ When all Spectra Support Services, LLC programs or initiatives involving the permitted use(s) specified in #2 are completed.
   - ❑ Other: _____

I understand that:

- I voluntarily agree to have audio and/or images recorded.
- I have the right to refuse to sign this authorization.
- Spectra Support Services, LLC will not condition treatment on whether I authorize the requested use or disclosure.
- I understand that I may request that specific sessions or parts of sessions not be recorded or that they be erased, and that I may at any time request to listen to a recording or see images.
- I understand that all recordings are CONFIDENTIAL and will be used by my therapist and his/her supervisor(s) for improving client's therapy.
- If I change my mind, I have the right to revoke this authorization, in writing, at any time, by sending a written revocation to Spectra Support Services, LLC located at 475 Lawrence Road, Broomall, PA 19008.
- A revocation is not effective to the extent that Spectra has already taken action based on this authorization and has made a USE or DISCLOSURE of the protected health information described above.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or state law.
- I have the right to inspect or copy the protected health information to be used or disclosed, as permitted under Federal law (or state law, to the extent the state law provides greater access rights).
- Once completed and signed, I will be given a copy of this document.

My signature below represents my acknowledgment and understanding.

Signature of Client/ Legally Authorized Representative Date Relationship to Client

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Print Client Name: **Client's Date of Birth:**

RECURRING PAYMENT AUTHORIZATION FORM

Schedule a payment to be automatically deducted upon each visit by charging your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started.

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your debit/credit card. You will be charged the amount indicated below each time the client named above attends a therapy appointment. The charge will appear on your bank statement and a receipt for each payment can be emailed to you upon request. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Spectra Support Services, LLC to charge my debit/credit card account indicated below for $_____ for each therapy appointment in which the above named client attend and for $35.00 for each therapy appointment which is not cancelled with greater than 24 hours' notice.

Name of Card Holder Relationship to Client

Billing Address Street City State Zip

Phone Email

Credit/Debit Card

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name

Account Number

Exp. Date

CV Number:

Signature **Date**

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Spectra Support Services, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next anticipated day of a charge. I certify that I am an authorized user of this credit/debit card and will not dispute these scheduled transactions with my debit/credit card company; so long as the transactions correspond to the terms indicated in this authorization form.