HRA PSYCHOLOGICAL SERVICES

New Client Intake

HRA Staff Only
HRA Staff Initials: ________ Intake Date: ______________ Provider: ______________________________
Appt Date/Time: _____________________________ Testing Date/Time: _____________________________

Name of person requesting the appointment: ____

Legal Client Name: ________________________________ Preferred 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
Parent/Guardian Name: __________________ Parent/Guardian 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.

I further give authorization to run my credit card if I choose to call and pay for services over the phone.

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

____ ____________
Legal Signature of Patient or Patient's Representative Date

____
Name of Patient (Print)

____
Relationship of Representative to Patient

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.

____ ___________
Legal Signature of Patient or Patient’s Representative Date

____
Relationship of Representative to Patient

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