**>Client Contact Information**

**>Informed Consent Agreement: Financial & Treatment**

**>Notice of Privacy Practices (NPP): HIPAA**

**>Consent to Treatment**

**Authorization**

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (First) (MI) (Last)

**Permission For Client Contact**: I prefer to be contacted in the following manner(s):

**Verbal communication may be made via:**

*Home*: Leave message with [ ] call back number ONLY or [ ] detailed information

*Cell*: Leave message with [ ] call back number ONLY or [ ] detailed information

*Texting:* [ ] Texting OK for appointment confirmation or cancellation (ONLY)

*(At staff discretion/participation)*

*Work*: Leave message with [ ] call back number ONLY or [ ] detailed information

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Chose: (Home) (Cell) (Work)

**Written communication may be sent via:**

*Home Address:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street) (City) (State) (Zip)

*Email*: [ ] Home or [ ] Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(At staff discretion/participation)*

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent Agreement: Financial & Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, regarding myself, DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**OR**

For my\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB: \_\_\_\_\_\_\_\_\_\_\_\_,

(relationship) (name of Client)

do hereby acknowledge by my/our signature(s) below on this Signature Page that I/we have received and/or reviewed and had the opportunity to discuss, understand and am in agreement with the Financial and Treatment Policies described therein.

~Furthermore, I acknowledge and grant consent to SOS: Seeking Out Solutions, Ltd. to disclose and/or exchange my Protected Health Information (PHI) with KASA Practice Solutions, a third party billing company, as well as my health insurance company, for the purpose of case management, utilization review, and/or the processing of claims including: insurance information, personal identification information and social history, fees, dates and types of service, diagnosis, mental status, progress reports, case notes, risk assessment, and treatment plan.

~Furthermore, I acknowledge and grant consent to SOS: Seeking Out Solutions, Ltd. to disclose and/or exchange my Protected Health Information (PHI) with Ther-A-Link, a third telehealth company for the purpose of telehealth services.

~Furthermore, I authorize my insurance carrier/other third-party payer to assign/pay benefits directly to SOS: Seeking Out Solutions, Ltd.

~Furthermore, I acknowledge that SOS: Seeking Out Solutions, Ltd. utilizes Electronic Health Records (EHR) and that my counseling records will be stored electronically via KASA Practice Solutions according to all applicable federal confidentiality regulations and HIPAA guidelines.

~ Furthermore, I acknowledge and grant consent to SOS: Seeking Out Solutions, Ltd. to disclose and my Protected Health Information (PHI) with Collection Companies, for the purpose of collecting past due bills over 90 days.

**Receipt of Notice of Privacy Practices (NPP)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, regarding myself, DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**OR**

For my\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(relationship) (name of Client)

do hereby acknowledge by my/our signature(s) below on this Signature Page that I/we have received and/or reviewed on **www.soscounseling.com** and had the opportunity to discuss, understand and am in agreement with the NPP.

**Consent to Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_, on behalf of myself,

*OR*

in my capacity as *(relationship to Minor or Dependent)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby attest to my legal status as [ ] SOLE *or* [ ] JOINT custodial parent *OR* as [ ] Guardian

of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby grant

consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to obtain and receive

Assessment and Counseling Services as provided by SOS: Seeking Out Solutions, Ltd., either in person and/or via telehealth.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

*I/we understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent. I/we understand the right to review the records to be released. I/we understand that this Release can be revoked at any time in writing prior to the information being released. Dev 03/2019*

 *Rev 06/2020*

**INFORMED CONSENT FOR VIDEO THERAPY SESSION (If Applicable)**

1. I understand that I am about to engage in a therapy session via video or phone.

2. I understand that the phone or video conferencing technology will not be the same as an in-person session with a therapist due to the fact that I will not be in the same room as my therapist. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.

3. I understand the potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the phone or video therapy session if it is felt that the phone or video conferencing connections are not adequate for the situation.

4. My therapist agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I agree to inform my therapist if there is another person present during the session.

5. I understand that taping my session is not permitted.

6. I understand that there are alternatives to a phone or video therapy session available, including the option of finding another provider to see in-person if available in my area.

7. I understand that I can direct questions about this phone or video therapy session at any time to my therapist.

8. I understand that this consent will last for the duration of the relationship with my therapist, including any additional phone or video therapy sessions I may have; I can withdraw my consent for a phone or video therapy session at any time and, my therapist will work with me to find a suitable alternative.

 9. I understand that the same confidentiality protections, limits to confidentiality, and rules around my records apply to a phone and video therapy session as they would to an in-person session.

10. I agree to work with my therapist to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions.

11. I understand that my therapist may decide to terminate phone or video therapy services, if they deem it inappropriate for me to continue therapy through phone or video sessions. My therapist will either provide in-person care or work to identify another therapist for in-person care.

**Agreement:**

By signing this form, I certify: ● That I have read or had this form read and/or had this form explained to me. ● That I fully understand its contents including the risks and benefits of the procedure(s). ● That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction. ● That I agree to participation in a phone or video therapy session(s) with my therapist.

 Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I/we understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent. I/we understand the right to review the records to be released. I/we understand that this Release can be revoked at any time in writing prior to the information being released. Dev 06/2020*