Client Information Sheet

Thank you for choosing us to assist you with your needs. Please answer the following questions so that we may be of better service to you, and sign the accompanying forms.

Name ____________________________________ Date: _________________

Partner/Spouse _________________________________

Address ____

Date of Birth: _______________________ Partner/Spouse DOB: ____________________

Home Phone: ___________________ Cell Phone: ___________________

Email (for receipts): _______________________ Partner/Spouse Cell Phone: ______________

Employer: _______________________________ Partner/Spouse Employer _______________________________

Annual Family/Household Income (if receiving a reduced rate): ____________________

Relationship Status (circle): Single/Never Married Married (Date:_________) Remarried (Date:_________)

Divorced (Date:_________) Widowed (Date: ________) Separated (Date:_________) Cohabiting (Date:_________)

Family/Household Members: (those living at home, and away from home)

Name	Age	Date of Birth	Sex	Relationship	Do they live with you?
______________________	___	__________	_____	______________	Y N
______________________	___	__________	_____	______________	Y N
______________________	___	__________	_____	______________	Y N
______________________	___	__________	_____	______________	Y N
______________________	___	__________	_____	______________	Y N

Briefly describe what brings you to therapy. ____

____

____

Have you participated in therapy before (circle)? Y N When? _______ Where? ________________

How satisfied were you with your previous therapy experience (circle)?

Very Satisfied Satisfied Somewhat Satisfied Not at all Satisfied

Please Explain: ____

Basic Physical Health: __Excellent __ Good __ Fair __ Poor Date of last physical exam ___________

Are you being treated for any specific illness? ______ Nature of the illness: ______________________________________

Are you taking any medication (or vitamins)? ______If yes, what? ____

____

Do you smoke? Y N drink? Y N What & how much? ____

How did you hear about Rooted Relational Therapy? ____

Any other information you would like to share? ____

____

____

Form updated 1.14.2024

Client Agreement, Indemnity & Consent Form

I/We, ____, have applied for therapeutic services with Rooted Relational Therapy (RRT) for myself/ourselves and/or the following persons for whom I/we am a legal guardian: ____.

I/We understand that there can be benefits to therapy such as improved communication, interpersonal relationships, or methods of coping. While I/we expect benefits from this treatment, I/we fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. I/we may experience emotional strains, feel worse during treatment, and make life changes that may be distressing.

I understand that the therapists at RRT are not providing an emergency service. I may leave a voice message at 570-884-4662, however, **if this is an emergency I will call Crisis Intervention** at 1-800-222-9016 or call 9-1-1. I recognize that text and email are **not** secure and confidential methods of communication and are **not** to be used in the case of an emergency.

Please initial below to affirm agreement:

_______Payment, Scheduling and Late/Cancellation

I/We understand that a therapy session is normally 50-53 minutes in length, and that payment is to be made at each session. I/We also agree to pay $165 ($135 out-of-pocket discount / private pay rate) for the first session, then $145 ($120 out-of-pocket discount / private pay rate) per session thereafter (add $5 per aforementioned private pay services if seeing one of our owners, Doug or Morgan Richard), and for co-therapy (two therapists): $210 after $245 initial session. Longer sessions may be scheduled at an additional cost. RRT desires to help regardless of financial situation, so if there is financial difficulty, I/we may inquire about reduced rates based on household income. I/We must provide proof of household income to receive reduced rates for offered services. If applicable, I/We agree to pay a reduced rate per 50-53 minute session. *If a check is returned for insufficient funds, a charge of $25 will be added to the unpaid fee.* ***RRT may pursue the use of a collection company for collection of unpaid balances after 30 days delinquent and two unsuccessful attempts to collect from client.***

I/We understand that I/we must have a credit card on file (or pre-pay a session fee) in order to ensure timely and proper payment of session fees. At the time of scheduling the next session, I/we commit to pay for that session. If I/we cancel or don't show up for the appointment, I/we will be billed according to the agreed upon schedule (***clients using insurance will be billed according to the out-of-pocket / private pay client fee schedule as we are unable to bill insurance in this circumstance***). I/we understand that the therapist has complete discretion on waiving that fee for medical emergencies, sickness, or other equivalent circumstances including weather-related emergencies. For clients with recurring appointments, any appointments after the next appointment may be rescheduled without penalty.

I/We understand that if I/we are using insurance the following additional *out-of-pocket / private pay* late fees, which are not covered by insurance and payable in addition to your co-pay/co-insurance, will be added to your bill and due at the time of your visit if I/we are late. 5 to 15 minutes late: 25% of session fee | 15 to 30 minutes late: 50% of session fee | Over 30 minutes late: 100% of session fee. If you are already paying out of pocket ("private pay"), then you will continue to be billed the full session fee regardless of tardiness.

______Legal and Ethical

I/We understand that when there is more than one person participating in therapy as in couples or family therapy, each person who has participated in any session must sign for any request for release of records to be honored.

I/We understand that conversations with the therapist and my/our records are confidential **except** in the following situations:

1. If I am at serious risk of harming myself or another person. (When under 18, chronic or increased substance abuse or acting out behavior may constitute danger to self or other and parents may be informed.)
2. If I am abusing or neglecting a child, an elderly person, or a disabled person in my care or I am the recipient of that abuse or neglect (or in any other mandated reporting situation, including but not limited to those in #7 of the Client Rights below).
3. A court order compelling my therapist to release records.

I/We also understand and give permission to the therapist to seek clinical supervision or consultation about my/our situation when necessary. This may include other staff of RRT as well as external professionals in a limited and confidential capacity.

I/We understand our therapist(s) will share information with supervisors. I/We also understand all clinical information will remain strictly confidential between the therapist(s), supervisor(s) and limited others in their training/educational program(s), and give permission for therapists/interns to do so. I/We understand that Morgan and Doug Richard as Clinical Directors provide clinical oversight for all therapists, and supervision for all pre-licensed therapists at Rooted, and that Elizabeth Holcomb is a Master's Level MFT Intern Therapist supervised by Doug Richard, MA, LMFT (PA License # MF001219). I/We understand that Kathryn Henderson, M.A., MFT, is a Master's Level Marriage and Family Therapist supervised by Morgan Richard, MA, LMFT (PA License # MF001134), and that Morgan and/or Donna Welsh, MA, LPC (PA License #

PC012153) supervise Sandra Lamey, M.A., CMHC and Carla Muniz-Lamboglia, M.S., CMHC, both Master's Level Clinical Mental Health Counselors.

I/We give permission to contact me/us via phone, email, and/or mail, including at home.

I/We give permission for RRT to contact and communicate with the subscriber of my/my child's insurance plan/EAP/HSA/HRA for billing purposes only (if necessary).

I/We are aware that any electronic communication, including email or text, with the therapist is not guaranteed to be secure. I/We understand that it may not hold full confidentiality though we still choose to use it. I/We understand that we choose to use technology for communication at our own risk.

______Telehealth

I/We understand that I/We have the right to withhold or withdraw my/our consent to the use of telehealth in the course of my/our care at any time, without affecting my/our right to future care or treatment.

I/We understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of personal information could be disrupted or distorted by technical failures, the transmission of personal information could be interrupted by unauthorized persons, and/or the electronic storage of personal information could be unintentionally lost or accessed by unauthorized persons. Rooted Relational Therapy, LLC utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via TheraNest.

I/We understand that Rooted Relational Therapy, LLC clinicians follow any/all State of Pennsylvania Regulations for telehealth as well as their respective board regulations and ethics. They have also received training to provide telehealth services.

I/We agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I/We are in crisis or in an emergency, I/We should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

I/We understand that Rooted Relational Therapy, LLC will bill for telehealth services in accordance with our standard fee schedule. When these services are provided by a participating therapist and have been determined to be covered by an individual's insurance plan Rooted Relational Therapy will bill insurance. The standard copay and/or deductibles would apply and I/We will be responsible for any amounts not covered by insurance.

_______Video Recordings (optional)

I/We understand that to further the skills of therapists, confidential video/audio recordings may be made of therapy sessions. I/we give my/our consent to allow video & audio recordings and that they may be used as clinical data for self-improvement and confidential clinical review by the therapist, supervisors and/or staff at Rooted (and within training/educational programs in a limited and confidential capacity), after which they will be destroyed.

If I/we am/are involved in a divorce or custody litigation, I/we understand that your role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this document, I/we agree not to call you as a witness in any litigation. I/we understand that only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans. If the therapist is subpoenaed, I/we agree to compensate the therapist at the rate of $500.00 per hour, paying the therapist *in advance* for a minimum of three hours ($1500.00) and within ten days for any additional hours. I/we realize I/we will be billed for hours including document preparation, travel expenses, meals, telephone time, parking and any and all legal counsel the therapist seeks regarding my/our case.

By signing below, I/we agree that I/we have read the above information as well as the attached Client Rights, Credit Card Consent and HIPAA NPP carefully, understand their contents, and agree to receive services for myself/ourselves and/or any child under the age of 14 under these conditions.

Client Signatures:

____ Date ________________

____ Date ________________

____ Date ________________

Witness Signature:

____ Date ________________

Client Rights

Your rights as a client include:

1. You are entitled to information about any procedures, methods of therapy, techniques, and possible duration for therapy.
2. You have the right to decide not to receive therapeutic assistance from us or to seek a second opinion from another therapist. We will provide you with names of other qualified professionals whose services you may prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligation other than those already accrued.
4. In a professional relationship, sexual intimacy between therapist and client is never appropriate.
5. You have the right to expect confidentiality within the limits described under #7.
6. Any records can be released to any person or agency you designate, if you request this and sign the appropriate consent forms. You may also authorize us to consult and share information with another professional concerning your therapy. (Please note that all clients involved in treatment must give written consent for release of information.)
7. There are certain situations in which we are required by law to reveal information obtained during therapy without your permission. These situations are: 1) if you threaten bodily harm or death to yourself or another person; 2) if a court of law issues a legitimate court order (signed by a judge); 3) if you reveal information relative to physical abuse, sexual abuse, or neglect of a child, elderly, or disabled person (in the present, as well as the past if the victim is currently under 18 years of age); 4) if you are in therapy by order of a court of law; or 5) if you are involved in a criminal or delinquency proceeding.

Credit Card Consent

I authorize Rooted Relational Therapy to charge my credit/debit/health account cards for professional services. I have read and understand their policy regarding payments, scheduling, lateness, and cancellations, including that I must have a credit card on file. I recognize that Rooted Relational Therapy will charge my card if I do not show up for an appointment or if I cancel an appointment outside of an emergency situation, and I will be billed for the full session charge, or in instances of lateness, remaining charges owed. I understand and agree that I am responsible for copays, coinsurance, deductibles and self-pay rates at the time of service. I authorize Rooted Relational Therapy to charge my card for any monies owed and outlined here that are not paid during my session or that are not paid by my insurance company. I understand that I am responsible for all charges whether or not they are paid by my insurance. I understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts.

I verify that my credit card information is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Credit Card Consent Signature: ____ Date: _______________

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

You have some choices about how we use your information. If you'd like to see the full Notice of Privacy Practices, just ask your provider or contact one of the privacy contacts below.

Rooted Relational Therapy LLC
434 Chestnut St. Mifflinburg PA 17844

Privacy Contacts: Doug or Morgan Richard, Owners
570-884-4662

Form updated 1.14.2024