The Center for Relationship and Sexual Health

Intake Form

Your answers to the questions presented here will give us some preliminary information about you enabling us to prepare for your first meeting at CRSH. If you have not sent the completed form to us by email, please bring it with you to your first session.

What type of therapy/counseling/coaching are you pursuing at this time?

Individual ☐ Couples ☐ Group ☐ Coaching ☐

Please share with us your reasons for seeking psychotherapy/counseling at this time: (check all that apply)				
☐ Depression	☐ Anxiety	☐ Relationship Issues	☐ Marital Issues	☐ Mood Disorders
☐ Sexual Issues	☐ Trauma	☐ Parenting/Children	☐ Grief/Loss	☐ Career/Work
☐ Addictions	☐ Sexual Identity	☐ Anger	☐ Substance Abuse	☐ Gender Issues
☐ Financial	☐ Other			
In your own words, briefly describe your reasons for seeking therapy/counseling:				

IF YOU ARE IN A RELATIONSHIP, PLEASE PROVIDE INFORMATION ABOUT YOUR PARTNER/SPOUSE ON THE SECOND PAGE OF THIS FORM

PLEASE PRINT CLEARLY **Today's Date: _____**

NAME: _____ Age: ____ Birthdate: _____
Last First Middle Initial Month/Day/Year

ADDRESS _____
Number and Street Name City State Zip Code

Primary Phone No: (_____)_____ Cell ☐ Home ☐ Work ☐ Other ☐

May we contact you & leave a message at this number? Yes ☐ No ☐

Emergency Phone No: (_____)_____

Contact Person Name: _____ Relationship _____

E-Mail Address: _____

May we contact you & send information to this email address? Yes ☐ No ☐

Gender: Male ☐ Female ☐ Transgender ☐ Gender Fluid ☐ Questioning ☐ Nonbinary (NB) ☐

Gender Queer ☐ None ☐

RACE		RELIGION		MARITAL STATUS	
☐ African American	☐ Hispanic	☐ Agnostic/None	☐ Jewish	☐ Single	☐ Married
☐ American Indian	☐ White	☐ Baptist	☐ Protestant	☐ Partnered	☐ Separated
☐ Asian	☐ Other	☐ Catholic	☐ Other	☐ Divorced	☐ Widowed

ROMANTIC / SEXUAL ORIENTATION			
☐ Heterosexual	☐ Gay	☐ Bi-Attraction / Bi-Sexual	☐ Unsure / Questioning
☐ Heteroflexible	☐ Lesbian	☐ Homoflexible	☐ Pansexual
☐ Queer	☐ Asexual	☐ Other	

PRONOUNS			
☐ He/His/Him	☐ She/Her/Hers	☐ They/Them/Theirs	☐

Children			
Name	Age	Gender	Reside at Home (yes/no)

EMPLOYMENT STATUS: Employed ☐ Unemployed ☐ Retired ☐

If employed, please provide the name of your current employer: _____

What is/was your position title at your current or last job? _____

How long have/did you work for your current/last employer? _____

INFORMATION REGARDING SPOUSE/PARTNER

PLEASE PRINT CLEARLY

NAME: _____ Age:_____ Birthdate: _____
Last First Middle Initial Month/Day/Year

ADDRESS _____
Number and Street Name City State Zip Code

Primary Phone No: (_____)_____ Cell ☐ Home ☐ Work ☐ Other ☐

May we contact you & leave a message at this number? Yes ☐ No ☐

Emergency Phone No: (_____)_____

Contact Person Name: _____ Relationship _____

E-Mail Address: _____

May we contact you & send information to this email address? Yes ☐ No ☐

Gender: Male ☐ Female ☐ Transgender ☐ Gender Fluid ☐ Questioning ☐ Nonbinary (NB) ☐

Gender Queer ☐ None ☐

RACE		RELIGION		MARITAL STATUS	
☐ African American	☐ Hispanic	☐ Agnostic/None	☐ Jewish	☐ Single	☐ Married
☐ American Indian	☐ White	☐ Baptist	☐ Protestant	☐ Partnered	☐ Separated
☐ Asian	☐ Other	☐ Catholic	☐ Other	☐ Divorced	☐ Widowed

ROMANTIC / SEXUAL ORIENTATION			
☐ Heterosexual	☐ Gay	☐ Bi-Attraction / Bi-Sexual	☐ Unsure / Questioning
☐ Heteroflexible	☐ Lesbian	☐ Homoflexible	☐ Pansexual
☐ Queer	☐ Asexual	☐ Other	

How long have you been together? _____

EMPLOYMENT STATUS: **Employed** ☐ **Unemployed** ☐ **Retired** ☐

If employed, please provide the name of your current employer: _____
What is/was your position title at your current or last job? _____
How long have/did you work for your current/last employer? _____

The Center for Relationship and Sexual Health

CLIENT CONTRACT

Welcome to The Center for Relationship and Sexual Health (CRSH). When people start counseling they usually have a lot on their minds and do not always remember details about office arrangements. Therefore, we are providing our policies in writing. Please take the time to read these thoroughly before your first appointment. If you have any questions, please bring them to the attention of your therapist. This document contains important information. Once signed, it constitutes a binding agreement between us.

1. **Fees**: Fees may vary depending on a number of factors (i.e., whether individual, couples or group sessions, length of sessions, etc.) Your therapist can review with you the details specific to your situation.

2. **Cancelled & Missed Appointments**: An appointment is a reserved time slot held just for you. If you must cancel, **48 hours** advance notice is required to avoid any financial obligation for that time slot. Failure to provide notice **48 hours** in advance constitutes a missed appointment and will result in you being billed the full fee of your scheduled session. However, if our schedules allow for another appointment in the same week, you will not be responsible for payment for that missed appointment. Insurance reimbursement does not cover missed appointments. Payment in full for the missed appointment is expected at the next session with your therapist.

3. **Payment**: We deeply value our relationship with you and honoring the payment commitment & process allows us to focus on your counseling and not on billing. To best serve you, the following payment process applies:

    a. Payment for professional services is expected at the time of each session.
    b. A credit/debit card is required to be on file to secure payment for services. **For your protection and peace of mind, your credit card information will be secured in our encrypted system.**
    c. Co-payment, Co-insurance, Deductible, and Self-Pay Patient Fees can be paid by cash, check or credit card. If paying by cash or check (made payable to the Center for Relationship and Sexual Health) please give that to our office manager or your therapist at the beginning of each session. If paying by credit card, your fee will be processed to your card following your session.
    d. Missed Appointment fees will be automatically charged to your credit/debit card in accordance with the CRSH Cancellation and Missed Appointment Policy.
    e. Some therapists at CRSH will bill your insurance directly. We will attempt to determine your coverage, deductible and co-pay. It is your responsibility to ensure the information is accurate. If your insurance declines payment, it is your responsibility to pay CRSH. Payment is expected at your next session for any amounts unpaid by your insurance company.
    f. Insurance is considered a method of reimbursing the patient for the fee paid to the Therapist and is not a substitute for payment. We try to work with your insurance company as a courtesy to you.

4. **Outpatient Mental Health/Therapy and Insurance:** Many of the costs of outpatient psychotherapy are covered by health insurance. **Please check with your insurance company if you are covered for this benefit**. There are a growing number of insurance companies and varied types of policies within these companies. It is very important that you know what **YOUR** insurance covers. Most companies will only provide this information to you and not to the professional providing the services. Benefit information can be obtained either through your employer's personnel/human resources office or directly to you from your insurance company.

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248-399-7447
www.crsh.com email: officemgr@crsh.com

The following guidelines will be helpful for inquiring about your mental health outpatient coverage for services at the Center for Relationship and Sexual Health.

a. **Ask for details about your outpatient psychiatric/mental health coverage**

b. **Ask if they reimburse for outpatient psychotherapy from a clinician working independently and out of network by choice**

c. **Ask if they cover the degree and licensure of the therapist you are scheduled to see**

d. **Ask if your policy has a requirement regarding licensure and degree (i.e., MD, PhD, MSW, MA or does it require the clinician to be supervised by an MD or PhD)**

In many instances, we are able to look up your eligibility and benefits on websites provided by the insurance companies. However, the insurance companies clearly state that the information on the website is not a contractual agreement and that the information is subject to change without notice. Therefore, ***while we can give you a good idea of eligibility and benefits, we cannot be held accountable for differences between what we quote to you as your eligibility and benefits (based on the website information) and what the insurance companies actually pay on your behalf. YOU are responsible for reviewing your insurance policy statements and Explanation of Benefits.***

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions, you should call your plan and inquire. The number for this inquiry is usually noted on the back of your insurance card at the bottom.

5. **Managed Health Care Plans:** HMOs and PPOs sometimes require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short term treatment approach, designed to resolve specific problems that are interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In our experience, while quite a lot can be accomplished in short term therapy, many patients feel that more services are necessary after insurance benefits expire.

   You should also be aware that insurance agreements may require you to authorize the therapist to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, we have no control over what they do with it. In some cases they may share the information with a national medical information data bank.

   Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for services rendered at CRSH yourself and avoid the complexities that are described above.

6. **Termination of Therapy/Counseling**: A scheduled orderly end of therapy/counseling is very important and can have a positive effect as you move forward. It is suggested that you openly discuss with your therapist at least three session prior to your last session your wish to end therapy. Closure sessions help you acknowledge and summarize what you have accomplished and give you the opportunity to review any unfinished concerns you may have.

7. **Notice of Privacy Practices (HIPPA)**: By signing this document you acknowledge that you have received and read the HIPPA notice and how your records may be used and disclosed. You may revisit the notice on our website: www.CRSH.com

8. **Confidentiality and Legal Proceedings**: In general, the confidentiality of all communications between a patient and a therapist is protected by law, and your therapist can only release information about your treatment to others with the written permission of the patient or his/her guardian. However, there are exceptions.

   We provide therapy and counseling to our clients relative to their personal needs. We do not provide evaluations for outside agencies nor do we treat anything relevant to a divorce or custody proceeding and will not testify or submit materials to aid in such proceedings. We also do not evaluate or treat anything specific to civil or criminal proceedings nor will we be available to testify or submit materials to aid in these types of proceedings. If such proceedings do come about, you will need to obtain additional treatment and/or evaluations from another licensed clinician (i.e., counselor, social worker, psychologist, and psychiatrist) that is trained in courtroom procedures.

   If we are court ordered to testify or offer evidence in any manner in any forum (including but not limited to writing letters to court, probation officers, etc.) then you will be charged the established rate set between you and your therapist at CRSH. Arrangement for payments of these fees must be finalized prior to any appearance by the Therapist.

   There are some situations in which your therapist is legally required to take action to protect others from harm, even though that may require revealing some information about a patient's treatment. If your therapist believes a minor, an elderly person, or a disabled person is being abused, s/he must file a report with the appropriate state agency. If your therapist believes that a patient is threatening serious bodily harm to another, s/he required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a patient threatens to harm him/herself, the therapist may be required to seek hospitalization of the patient, or to contact family members or others who can help provide protection. Should such a situation occur, your therapist will make every effort to fully discuss it with you before taking any action.

   Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, s/he will make every effort to avoid revealing the identity of any patient. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, s/he will not tell you about these consultations unless s/he feels that it is important to your work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important to discuss any questions or concerns which you may have as soon as possible. As you might suspect, the laws governing these issues are quite complex.

It is important for you to understand that we cannot guarantee confidentiality of communication by email and text. While our electronic online files are encrypted, our emails and texts are not. We certainly do our best to keep any type of communication with you private and confidential. But while you are welcome to make use of these communication tools, you do so at your own risk.

By signing this agreement, you acknowledge that you have read this document and understand and agree to all the policies and procedures of The Center for Relationship and Sexual Health.

_____	_____	_____
Print Client Name	Client Signature	Date
_____	_____	_____
Print Client Name	Client Signature	Date
_____	_____	
Therapists Signature	Date	

About Cancelled and Missed Appointments

Missed and short notice cancellations are taken very seriously. We understand that things come up which sometimes are out of your control which may prompt the need to cancel an appointment.

If you must cancel, **48 hours** advance notice is required to avoid any financial obligation for that time slot. Notification may be accomplished by sending a voicemail or email message. If done by email, you will need to have confirmation that the email was sent and received.

Failure to provide notice **48 hours** in advance is considered the same as a missed appointment and will result in you being billed the full fee of your scheduled session.

If our schedules allow for another appointment in the same week, you will not be responsible for payment for that missed appointment. Insurance reimbursement does not cover missed appointments. Payment in full for the missed appointment is expected at the next appointment.

An appointment reserves a time slot just for you. Please understand that without advance notice of cancellation we are unable to fill that time slot to serve the needs of another who desires or requires a counseling session. Your therapist will consider any feelings and thoughts you may have about being charged for a missed appointment and invite you to discuss this with them.

_____ _____ _____ _____

Client Signature Date Client Signature Date

_____

Therapist Signature

About Insurance Reimbursement

We will attempt to determine your insurance coverage, deductible and copay, however, it remains your responsibility to ensure the information is accurate. We can give you a good idea of eligibility and benefits, we are not responsible for differences between what we quote to you as your eligibility and benefits (based on the website information) and what the insurance companies actually pay on your behalf. YOU are responsible for reviewing your insurance policy statements and Explanation of Benefits. It is also your responsibility to pay the Center for Relationship and Sexual Health if your insurance carrier declines payment. Payments are expected at the next session for any outstanding balances not reimbursed by insurance.

We also require a credit card to be kept on file with CRSH so that we can collect any outstanding fees not reimbursed from insurance.

By signing this form, you are agreeing to allow us to bill your credit card for unpaid and missed session fees.

_____ _____ _____ _____

Client Signature Date Client Signature Date

_____

Therapist Signature

The Center for Relationship and Sexual Health

Authorization for Credit Card Use

Please print (except for signature line)

Name on Credit Card: _____

Billing Address: _____
Street Address Apt Number

_____
City State Zip Code

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ AmEx

Circle One: Credit Debit HSA

Credit Card Number: _____ **Exp. Date**_____

Security /Validation Code: _____

ONE TIME CHARGE: Amount to Charge: $ _____ (USD)

I authorize The Center for Relationship and Sexual Health to charge the amount written above to the credit card provided herein for services rendered to _____. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Signature: _____ Date: _____

RECURRING CHARGES:
I authorize The Center for Relationship and Sexual Health to charge future session fees, missed session fees, and/or insurance deductibles, co-pays, and/or co-insurance payments to the credit card provided herein for services rendered to _____. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify The Center for Relationship and Sexual Health (CRSH) in writing of any changes in my account information or termination of this authorization prior to the next scheduled therapy session. In the case of a Transaction being declined, I understand that CRSH may, at its discretion, attempt to process the charge again within 30 days. If it is declined again, I agree to provide another means of payment prior to any further services provided by CRSH. I certify that I am an authorized user of this credit card/bank account and will not dispute these transactions with my bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form.

Signature: _____ Date: _____

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The Center for Relationship and Sexual Health

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPPA"), regulations promulgated under HIPPA including the HIPPA Privacy and Security Rules, and the *NASW Code of Ethics.* It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Notice of Privacy Practices

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPPA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPPA

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor of administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPPA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, incompliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Notice of Privacy Practices

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Dr. Joe Kort at 248-399-7317

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a 'designated record set'. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. We may also request that a copy of your PHI will be provided to another person.

Notice of Privacy Practices

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer, Dr. Joe Kort, if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of caring out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Dr. Joe Kort at 248-399-7317 or with the Secretary of Health and Human Services at 200 Independence Ave., S.W., Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013

25600 Woodward Ave – Suite 215 – Royal Oak, MI 48067
248-399-7447
www.crsh.com email: officemgr@crsh.com

The Center for Relationship and Sexual Health

Notice of Privacy Practices and Insurance Release
Receipt and Acknowledgment of Notice

Client Name: _____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of The Center for Relationship and Sexual Health Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact my therapist or the Center for Relationship and Sexual Health at 248-399-7447

I hereby authorize the release of any medical or other information necessary to verify & validate insurance coverage and validate & process insurance claims. I also request payment of government benefits, if applicable, to the Center for Relationship and Sexual Health. I understand that billing my insurance company does not guarantee that they will pay for services rendered. If my insurance company denies payment for any reason, I agree to pay out of pocket for the sum of the services provided.

_____ _____
Client Signature/Signature of Guardian* **Date**

_____ _____
Signature of Staff Member **Date**

❑ **Client Refuses to Acknowledge Receipt**

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)._____
_____
_____

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The Center for Relationship and Sexual Health

INFORMED CONSENT CHECKLIST FOR TELEHEALTH SERVICES

Prior to starting telehealth services, we discussed and agreed to the following:

- There are potential benefits and risks of telehealth (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telehealth services, and nobody will record the session without the permission from the others person(s).
- We will agree upon the telehealth platform for our virtual sessions.
- It is important to be in a quiet, private space that is free of distractions during the session.
- It is important to use a secure connection rather than public/free Wi-Fi.
- It is important to be on time. The same 48-hour cancelation policy applies to telehealth sessions.
- If you need to cancel or change your appointment, you must notify us within 48 hours in advance by phone or email.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.
- We have discussed your telehealth insurance eligibility. It is understood that if your insurance company does not reimburse your sessions, you are responsible for full payment. Our rates for telehealth services, not covered by insurance, have been discussed and agreed upon.
- As your therapist, I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume sessions in-person.

Therapist Name: _____

Patient Name: _____

Signature: _____

Patient _____ Parent/Legal Guardian _____

Date: _____