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FUNCTIONAL HEALTH
COUNSELING • CHIROPRACTIC • NUTRITION

Mental Health New Patient Forms

Date | Full (LEGAL) Name | Preferred Name

Street Address | City/State/Zip Code

Home Phone Number | Cell Phone Number | Email Address

Date of Birth | Age | Social Security Number

Employer Name and Address

Work Phone Number | Occupation | Years at Current Employer

Phone Number you would like to receive appointment confirmation text: _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Insurance/Billing Information

□ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Insurance Company**/Phone#** | **Subscriber's Name** | **Relationship To You**

Insurance ID # | Subscriber's SSN | Subscriber's Date Of Birth

Emergency Contact Name | Relationship to the Patient | Phone Number

Medical Physician's Name | Medical Physician's Phone Number

Who may we thank for **referring you** to the office?

****To prevent billing errors**, we ask all patients share a copy of their current insurance card upon renewal

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Health History

For what reasons are you seeking services? Please list below:

_____

_____

Please check below if you are experiencing any of the following symptoms:

□ Sadness	□ Panic	□ Easily Frustrated
□ Crying Episodes	□ Phobia	□ Annoyed
□ Worthlessness	□ Social Phobia	□ Yelling / Screaming / Ranting
□ Hopelessness	□ Exposure to Trauma	□ Physical Violence
□ Suicidal Thinking	□ Restlessness	□ Destruction of Property
□ Loss of Pleasure	□ Easily Fatigued	□ Feeling Time Pressured
□ Insomnia	□ Difficulty Concentrating	□ Impatience
□ Sleeping Too Much	□ Irritability	□ Tension
□ Fatigue	□ Muscle Tension	□ Thoughts of Revenge
□ Excessive Guilt	□ Sleep Disturbance	□ Excessively Defensive
□ Low Self–Esteem	□ Internal Agitation	□ Hostility

Current Medical Problems: _____

Current Medications (Prescription and Over the Counter):_____

_____

_____

_____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature_____ Date_____/_____/_____

For use and/or disclosure of Protected Health Information (PHI) to carry out treatment, payment and healthcare operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Curis Functional Health's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Curis to provide treatment to me, and also necessary for Curis to obtain payment for that treatment and to carry out the health care operations. Curis explained to me that the Privacy Notice would be available to me in the future at my request. Curis has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Curis reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. Curis's "Notice of Privacy Practices" is also provided in the front lobby. I may also request a copy from this office at any time via US Mail, or email.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

*****I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

Office Policy, Acknowledgements, and Consents

- I understand that the cost of services is payable at the time the service is rendered.
- I understand that the Insurance Benefits quoted to me are not a guarantee of payment from my insurance company. If my insurance company processes claims differently than the benefits are described to me, I am responsible for any additional money that may be owed since per the insurance company, verification of benefits is not a 'guarantee for payment rendered'.
- I agree to pay Curis any outstanding bills that have been denied by my insurance company, and I am aware that uncollected bills over 90 days past due could be sent to an outside collection agency, and/or legal action may be taken. I also understand that Curis reserves the right to bill past due balance for a finance fee, up to 1.5% of that current balance/amount owed.
- I agree to pay Curis any deductible amounts and any copayments that may be affiliated with my insurance plan.
- It is my responsibility to inform Curis of any changes in insurance benefits. If services are rendered during a time of non-coverage, I understand that I am responsible for full payment of services.
- As a patient, it is MY responsibility to understand my insurance policy/limitations. Curis staff will discuss costs and verify benefits as a service to me, however, any services that are rendered as a part of my care, are ultimately my responsibility.
- *Out of common courtesy to other patients and our providers, please do your very best to be respectful of the time you reserve for appointments. We do our best to remind you of your appointments but ultimately,* ***the appointments you make are your responsibility****. Appointment reminders go out 24-48 hours prior.*

<u>Mental Health</u> - No Show/Failure to provide 24-hour notice may result in a $75 charge to your account. Any credits on accounts will be used for the cancellation fee. **If there is a pattern of no show/failure to cancel, it is up to the discretion of the service provider whether to continue to schedule further appointments.

By signing this document, you agree to the above terms

Patient Name	Patient Signature	Date
Parent or Guardian Name	Patient or Guardian Signature	Date

400 SW Longview Blvd, Lees Summit, MO 64081 / 816-761-3944

Informed Consent for TeleMental Health Services

The following information is provided to clients who are seeking TeleMental health therapy. This document covers your rights, risks and benefits associated with receiving services, our policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

TeleMental Health Defined:

TeleMental health means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery. Your health care information may be shared with other individuals in the office for scheduling and billing purposes. This document will become a part of your permanent health record.

Limitations of TeleMental Health Therapy Services

The laws that protect the confidentiality of my personal information also apply to TeleMental health. The same standard of care that would apply to an in-person visit also applies to Telehealth. While TeleMental health offers several advantages such as convenience and flexibility. It is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, we might not see various details such as facial expressions. Or, if audio quality is lacking, we might not hear differences in your tone of voice that we could easily pick up if you were in the office. There are ways to minimize interruptions and maximize privacy and effectiveness. As the therapist, I will take every precaution to ensure technologically secure and environmentally private psychotherapy sessions. As the client, you are responsible for finding a private quiet location where the sessions may be conducted. Consider using a "do not disturb" sign/note on the door. The virtual sessions must be conducted on a wifi or hardline connection for the best connection and to minimize disruption.

In Case of Technology Failure

We understand that during a TeleMental health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call the office back at: 816-761-3944 to reschedule.

Structure and Cost of Sessions

We provide virtual psychotherapy if your treatment needs determine that TeleMental health services are appropriate for you. **Please remember that your insurance company may or may not cover therapy via phone or video**. We are both responsible for understanding your mental health benefits. Please contact your insurance provider to verify coverage via TeleMental health.

The structure and cost of TeleMental health sessions are exactly the same as face-to-face sessions. Texting and emails (other than just setting up appointments) are billed at the hourly rate ($150/hr) for the time spent reading and responding. For TeleMental Health services, we require a credit card ahead of time for ease of billing. Please sign the Credit Card Payment Form, which was sent to you and indicates that we may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental health interaction for the amount determined by your insurance company (your copay, amount toward deductible, etc).

Electronic Transfer of PHI and Credit Card Transactions:

We may send the credit card-holder an email receipt indicating that you used that credit card for our services, the date you used it, and the amount that was charged. This notification is usually set up upon your request at the time the card is run. Please know that it is your responsibility to know if you or the credit card-holder has requested the receipt notification in order to maintain your confidentiality. Additionally, please be aware that the transaction will appear on your credit card bill. You can send secure documents through Rejuvenate including payment information. We will use this as the primary method of communication regarding payment and other personal health information related sharing.

Cancellation Policy

In the event that you are unable to keep your TeleMental health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed at the charge of $45.00. Please note that insurance companies do not reimburse for missed sessions.

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to email because it is a quick way to convey information. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that we are required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely matter. Instead, please see below under "Emergency Management Plan".

Emergency Management Plan

Your Rejuvenate therapist will see you in the event of a crisis. If we are unavailable we will provide the contact information of a colleague. If a colleague is unavailable in the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify two (2) nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. **These all must be completed to participate in TeleMental health services.**

1. Hospital Name, Location, and Telephone Number

   _____

2. Hospital Name, Location, and Telephone Number

   _____

3. Hospital Name, Location, and Telephone Number

   _____

Emergency Contact Person: _____

Relationship_____ Telephone Number: _____

You may alternatively follow this plan:

1. Call Lifeline at 800-273-TALK (8255)
2. TEXT NAMI to 741-741
3. Call 911.
4. Go to the emergency room of your choice.

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Consent to Treatment

I, hereby voluntarily agree and give my consent for the use of TeleMental health services to receive online therapy services for an assessment, continued care, treatment, or other services and authorize a therapist from Rejuvenate, Inc. to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Rejuvenate, Inc. at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Please use technology with discretion. Only communicate limited information such as appointment requests, cancellations, or estimated time of arrival.

I consent to the use of the following forms of communication via technology:

- ___ Texting
- ___ Email
- ___ Fax
- ___ Recommendations to Websites or Apps

_____

Patient/Client Signature Parent, Guardian or Legal Representative Signature ***(if minor or needed otherwise)***

_____

Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____

Psychologists Signature and Date

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Curis Functional Health is an Integrated Wellness Center

The Mind & Body are ONE – optimal health requires that you are treating BOTH!

Curis' Doctors of Chiropractic, Mental Health Professionals & Dietitians / Nutritionists offer a greater spectrum of services in the same office.

Your health is our top priority! At Curis Functional Health we make it easy to get the care you need.

Please check all areas of interest below so we can help streamline your treatment:

_____ **I'm interested in scheduling an appointment to see a Curis chiropractor.**

- Chiropractors help with back pain, neck pain, headaches, bulging/herniated disc and much more

_____ **I'm interested in making an appointment with a Mental Health professional**

- Anxiety, Depression, problems in relationships, stress, parenting, trauma, anger, help for my child

_____ **I'm interested in scheduling a FREE Consult with a Curis Dietitian, Nutritionist, or Weight Loss Coach**

- Our DNA-based metabolic program removes the guesswork and provides you with a personalized, sustainable plan for weight loss and control. The average client loses 20+/- pounds in the first 40 days! Coaching, support and accountability helps you achieve your goals big or small - according to YOUR genetics.

_____ **I'm interested in scheduling a consultation to discuss adding supplements to enhance my overall health.**

- Problems with Pain & Inflammation Relief, Arthritis, Disc & Joint Support, Cold & Immune Support, Stress & Anxiety Relief, Advanced Sleep, Brain Optimization, Natural Allergy Solutions