Real Solutions Counseling

1011 W. Williams St., Ste. G, Boise, ID 83706
Phone: (208) 991-0222 Fax: (208) 344-0014

Insurance/Medicaid Information Sheet

Client Name_____ Birth Date_____
MM DD YY

Print Parent or Guardian Name _____ Phone Number _____

Client Address_____ Emergency Contact _____

_____ Emergency Phone _____

Primary Insurance Company _____ ID number _____

Medicaid: ◯ Yes ◯ No If yes, list Medicaid Number: _____

If Medicaid is your only insurance please skip to signature line – if not, we need Primary insured name and date of birth

Insured's Name_____ Birth Date _____ Gender: ◯ Male ◯ Female

Primary Insured's Social Security Number _____

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that RSC will attempt to get accurate information regarding my mental health insurance benefits. I will not hold RSC liable for insurance non-payment due to misquoted benefits. I acknowledge I am responsible to know and understand my benefits plan. RSC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request assigned benefits be paid to RSC.

_____ _____
(Client Signature) (Date)

_____ _____
(Parent or Guardians Signature) (Date)

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YOUR RIGHTS AS A CLIENT

CONFIDENTIALITY OF RECORDS

The Health Insurance Portability and Accountability Act (HIPAA) states that information in your records may not be given to any other person without your written consent, or a court subpoena. A copy of RSC's privacy rules are posted on our website: www.kunacounselingcenter.com.

- Mental health professionals also have the right, when they deem necessary, to consult with another member of a supervisory and clinical team regarding treatment.
- Mental Health Professionals are required by law to report all incidents of child abuse.
- Mental Health Professionals may seek additional help for you if you are deemed to be a danger to yourself and others.
- Under no other circumstances may the therapist communicate information about you outside of RSC without a written consent.
- HIPPA Privacy rules are posted in our office, and you may have a copy upon request.

TO HAVE ACCESS TO YOUR RECORDS

HIPPA provides that if you request that your records be sent to another professional or agency, your request will be fulfilled with promptness upon receipt of your written request for transfer of information and provided there is no outstanding balance on your RSC account. There may also be an additional fee associated with this request. You may also request a personal copy of your medical records**, excluding therapist progress notes**, with a signed request form. You may be subject to a 7-day waiting period before receiving your records and there may be a nominal fee associated for cost of copying records.

INFORMED CHOICE AND CONSENT FOR COUNSELING SERVICES

Real Solutions Counseling will provide Counseling Services. The goal of counseling services is to assist participants with emotional and mental disorders including assessment, treatment, and management. It is also to aid them in recovery of both acute and chronic symptoms of their mental and emotional disorders. There are risks and benefits which may occur in counseling. The risks to therapy often involve discussing unpleasant aspects of your life, and you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behavior can be scary, and sometimes as you change, the relationships around you may change. However, the benefits of counseling typically outweigh the risks. The benefits from counseling may be an improved ability to relate with others, a clearer understanding of self, values, goals, increase productivity in work, school, and relationships, and an improved ability to deal with everyday stresses. Counseling may help relieve the stress and impaired functioning associated with trauma, grief and mental disorders. In fact, recent research has demonstrated that some types of psychotherapy offer better or equal treatment results at a lower cost than medication.

YOUR RIGHT TO REFUSE

You have the right to refuse any service which you do not want, or to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notification could be placed in your records.

I understand that I have the right to refuse Counseling services, and I have selected: **Real Solutions Counseling.** My reason for selecting this agency is:

_____

I have read, understand and accept the above statements concerning my (our) rights as clients of RSC including privacy practices and the scope of clinical services available.

Client Signature Date

GRIEVANCE PROCEDURE

You have the right to have your concerns/grievances heard and addressed appropriately. Real Solutions Counseling, LLC has an open door policy and desires to help you resolve any concerns to insure that your experience here is positive. Additionally, there are protection, advocacy, and legal services available to help you including, but not limited to, the Idaho Mental Health Coalition (658-2000), the National Alliance for the Mentally Ill (208-673-6672), the Idaho Human Rights Commission (208-334-2873), Idaho Legal Aid (208-345-0103 ext. 0), and Idaho Volunteer Lawyers (800-221-3295). Last, as a client, you have the right to make complaints regarding ethical concerns of a service provider to the Bureau of Occupational Licenses at 208-334-3233.

If the complaint is a general issue regarding the building, lobby, or other issue outside of the therapeutic process, you may inform your counselor or service provider, or any office staff. If the complaint or problem is with your counselor or other service provider, we ask you to first inform them of the concern and attempt to address it with them. However, if you are unable to resolve your concern, or do not feel safe to approach your counselor or other service provider with your concern, you may notify the clinical director. This can be done by telling one of the administrative assistants that you have a concern that you would like to address with the clinical director. The clinical director will help you mediate a solution to your concern or will provide alternative services/providers to meet your needs.

In signing this I am acknowledging my understanding of this policy as a recipient of services through Real Solutions Counseling.

_____ _____

Client/Parent/Guardian Signature Date

_____

Client Printed Name

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TECHNOLOGY ASSISTED COUNSELING (TAC)
CONSENT, POLICIES, & AGREEMENT

This form is in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Technology Assisted Counseling (TAC) sessions. TAC incorporates phone and video counseling.

Benefits: The benefits to TAC counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from and office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients, clients with limited mobility, clients with risk for contracting diseases, and clients without convenient transportation options.

Limitations: It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. If video is not used, I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the TAC counseling session.
4. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics: When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused and engaged in the session. I am calling you from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. For the most effective treatment, please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment. Please know that per best practices and ethical guidelines I can only practice in the state(s) I am licensed in. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Phone Sessions: If we lose our phone connection during our session, I will call you back immediately. If we are unable to reach each other due to technological issues, I will attempt to call you 3 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should we resume contact, and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

Connection Loss During Video Sessions: If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. Please also attempt to call me through your doxey.me link if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you 3 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session.

Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via phone or plan an alternate time to complete the remaining minutes of our session.

Recording of Sessions: Please note that recording, screenshots, etc. of any kind of any session is not permitted and are grounds for termination of the client-therapist relationship.

Payment for Services: Payments for services must be made **prior** to each session. I will charge your card on file or send you an invoice. Payment is to be completed prior to our session.

Cancellation Policy: If you must cancel or reschedule an appointment, 24-hour advance notice is required, otherwise you will be held financially responsible. Should you cancel or miss an appointment with notification less than 24 hours this will result in being charged the ***no show*** for your missed appointment. Cancellations must be communicated by phone, NOT email or text. If the client cancels or misses the session with less than 24 hours notice and the session is pre-paid, this follows the cancelation guidelines and the payment will not be reimbursed for the missed or canceled session less than 24 hours. Video/Phone sessions should be treated as regular in office sessions. If you are late getting on the video session, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

Emergencies and Confidentiality: I request an emergency contact for you. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

_____

Full Name Relationship Number(s)

I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

_____

Street Address

_____

City State Zip Code

_____

City and State of Local Police Department Phone Number

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433 or (800-273-TALK).

If I have concerns about your safety at ***any*** time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in TAC Sessions:

By signing below you agree that you have read and understand all of the above sections of TAC informed consent. You agree that you also understand the limitations associated with participating in TAC counseling sessions and consent to attend sessions under the terms described in this document.

_____

Client Name (Print)

_____ _____

(Client/Parent/Guardian Signature) (Date)

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Missed /Cancelled Appointment Policy

Thank you for your courage in taking the steps to seek counseling for you or your family's needs. In order to serve you and others with the highest quality of services we must be clear on our missed appointment policy. Time is important to all of us.

- It is the policy of Real Solutions Counseling that if you are unable to keep an appointment, you must contact the counseling center at least 24 hours in advance. You may cancel by calling 208-922-9001, which is available 24 hours a day, Monday through Friday and records the time of call.
- If you have a cancellation or missed appointment after the 24-hour deadline, you may be removed from the counselor's schedule and lose your access to that scheduled time in the future. You may be put on the counselor's waiting list and be scheduled at a time slot in the future that is available on the counselor's schedule.
- The second missed or cancelled appointment after the 24 hour deadline, you may be removed from RSC's schedule and be referred to another agency.
- Medical emergencies will be taken into consideration for not making the 24hr deadline, if you provide as much notice as possible and you may be asked to provide a doctor's note.

Facility Use Fee

People Empowerment Services Property Management leases these facilities for counseling services to Real Solutions Counseling (RSC) at 145 E. Deer Flat Rd. People Empowerment Services Property Management mandates a minimum number of sessions and minimum facility fee cost per session. People Empowerment Services Property Management has designated this facility fee as non-refundable after the 24hr deadline before your appointment.

For any session that you miss or choose to cancel after the 24 hr deadline, you will personally be liable for the $20 facility booking fee, which must be paid to People Empowerment Services Property Management before RSC can schedule your next session. Please make all checks or payment out to People Empowerment Services or contact RSC within five business days to pay your fees. RSC will not be permitted, per contract, to schedule further appointments with you until payment has been received.

In signing this I am acknowledging my understanding of this policy and my commitment to abide by the policy as a recipient of services through Real Solutions Counseling.

_____ _____

(Client/Parent/Guardian Signature) (Date)

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REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION

Latest health and physical is required by Medicaid. Please list current doctor's office on "TO" section below.

Clients Name: _____ **Date of Birth:**_____

SPECIFIC TYPE/EXTENT OF INFORMATION TO BE DISCLOSED:

Medical record from last Doctor Appt._____

PURPOSE OR NEED FOR THIS DISCLOSURE:

To coordinate best care for the client._____

I understand that this information may be sent by fax, mail or telephone.
__Yes __No
It is ok to send assessment and treatment information to the doctor's office.
__Yes __No

To/From:
REAL SOLUTIONS COUNSELING
1011 W. Williams St., Suite GZ
Boise, ID 83706
Fax #208-344-0014

From/To:
_____
_____
_____
_____

I have carefully read, and understand, the foregoing. I voluntarily consent to the release of the above specified information about or medical records of my condition and the treatment and services I have received to those persons or agencies listed. I further release my counselor from any liability arising from the release of this information or records to such designated persons or agencies. This consent is subject to revocation at any time and will expire on _____ or if no date specified expires 1 year after date of signing.

_____ Date: _____
Client/Guardian Signature

NOTE TO AGENCY/PERSON IN RECEIPT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CRF Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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FOR OFFICE USE ONLY
ID #_____
FAMILY MEMBER _____
TODAY'S DATE _____

Age_____ Sex_____ (Male/Female)

Marital Status:
☐ Married ☐ Never Married ☐ Divorced/Separated ☐ Living With Partner ☐ Widowed

Ethnic/Racial Group:
☐ African American ☐ Caucasian ☐ Native American ☐ Hispanic ☐ Asian American ☐ Other

Ever Treated For: (Check all that apply)
☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Post-Traumatic Stress Disorder

Ever Seriously Considered Suicide?
☐ Yes ☐ No

Please list any medical conditions: _____

CAD Depression Questionnaire

For the questions below, select one option for each question that comes closest to your answer. Over the past two weeks, how often have you:	None or little of the time	Some of the time	Most of the time	All of the time	Staff Use Only
1. experienced sadness, weepiness, or crying spells?	☐	☐	☐	☐	
2. felt hopeless, pessimistic or discouraged about the future?	☐	☐	☐	☐	
3. not been able to enjoy things?	☐	☐	☐	☐	
4. felt tired, slowed down, or had no energy?	☐	☐	☐	☐	
5. felt no interest in doing things.	☐	☐	☐	☐	
6. had difficulty falling asleep or with sleeping too much?	☐	☐	☐	☐	
7. had difficulty with concentrating, or making decisions?	☐	☐	☐	☐	
8. had no appetite, or found yourself eating when not hungry?	☐	☐	☐	☐	
9. felt guilty or worthless?	☐	☐	☐	☐	
10. felt like you wanted to die or wished you were dead?	☐	☐	☐	☐	
11. felt restless, worried, or nervous?	☐	☐	☐	☐	
12. had physical problems such as headaches, stomachaches, or chronic pain?	☐	☐	☐	☐	
The CADIC Depression Screening Questionnaire is the property of Real Solutions Counseling and may not be copied or used without express permission.			**Total Score:**		

The GAM Assessment

In your lifetime have you ever had a week where you:	YES	NO	Staff Use Only
1. felt excessive energy to the point of being hyper, overexcited, or giddy?	☐	☐	
2. had such an unusually high or good mood that others thought you were not yourself?	☐	☐	
3. felt like your mind was flooded with ideas and your thoughts were racing?	☐	☐	
4. did not need as much sleep as you normally do?	☐	☐	
5. acted impulsively by participating in risky or irresponsible behavior (i.e. wild shopping sprees, excessive speeding)?	☐	☐	
6. felt more interest in exciting, pleasurable activities than you usually do?	☐	☐	
7. felt more outgoing, rowdy, or socially open than you regularly do?	☐	☐	
8. found yourself easily distracted by the things going on around you?	☐	☐	
9. felt easily irritated or annoyed by regular everyday things?	☐	☐	
		Score:	
10.**If you checked "yes" to more than one of the questions above, did they occur in combination with each other?	☐	☐	
11. How big of a problem did these cause you? ☐ None ☐ Mild ☐ Moderate ☐ Severe			
Have you ever had any direct blood relative (parent, child, sister, brother) with depression, manic-depression, or who was psychiatrically hospitalized?	☐	☐	
The GAM Assessment is the property of Kuna Counseling Center. All rights reserved. Duplication or use for any other purpose is prohibited.		**Total Score:**	

Please turn this form over and complete the backside. Thank you.

CAAP Anxiety and Panic Questionnaire

During the past six months for a majority of the days have you:	YES	NO	Staff Use Only
1. felt nervous and anxious about things at work, home, or school?	☐	☐	
2. had difficulty controlling worries or fears?	☐	☐	
3. felt restless, nervous, or on edge?	☐	☐	
4. felt tired, exhausted, or easily worn out?	☐	☐	
5. had difficulty concentrating?	☐	☐	
6. felt easily annoyed, irritated or frustrated?	☐	☐	
7. had difficulty with tense or tight muscles?	☐	☐	
8. had trouble falling asleep or with frequent waking during the night?	☐	☐	
9. worried excessively about the usual issues in your every day life?	☐	☐	
10 had others notice that you worry or been told that you worry too much?	☐	☐	
11. had these worries cause noticeable problems in your daily life or caused a lot of distress for you?	☐	☐	
Total Score:			
12. **Additionally, have you ever had a distinct moment in time where you felt intense fear and distress, and experienced at least 3 of the following: shaking or trembling, sweating, loss of breath, feeling dizzy or out of control, chills or hot flushes, rapid heart beat, nausea, or fear of dying?	☐	☐	

TASA Trauma and Stress Assessment		
Have you ever had or seen a traumatic event where possible loss of life, severe injury or threat of physical well-being was involved?	YES ☐	NO ☐
Did you feel fear or helpless during or after the event?	YES ☐	NO ☐

If you answered "Yes" to questions 1 & 2, please proceed to the next Section

During the past week for most days have you?	YES	NO	Staff Use Only
1. experienced reoccurring and unwanted flashbacks, nightmares, or reminders of the event?	☐	☐	
2. have you made efforts to avoid thinking or talking about this event, or doing things that remind you of it?	☐	☐	
3. have you felt less interest in people and things, a feeling numbness, or trouble experiencing emotions?	☐	☐	
4. have you felt nervous, jumpy, or had a sense of heightened alertness?	☐	☐	
5. have you had trouble with irritability, falling or staying asleep, or with concentrating?	☐	☐	
Total Score:			

THANK YOU FOR COMPLETING THIS FORM. PLEASE RETURN IT TO A STAFF MEMBER TO BE SCORED.

RESULTS AND RECOMMENDATIONS-FOR OFFICE USE ONLY

Follow up is needed for: (Check all that apply)

- ☐ Depression
- ☐ Bi-Polar Disorder
- ☐ Generalized Anxiety Disorder
- ☐ Panic Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ No follow-up needed