



Adult  
Psychological Testing & Evaluation  
Intake Packet



**Office Use Only:**

Therapist: \_\_\_\_\_

Dx: \_\_\_\_\_

**Patient Information** *(Please print and complete form in its entirety)*

Name (First, MI, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender Identity: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Is it okay to leave confidential information in a voicemail at the above numbers?  Yes  No

Email Address: \_\_\_\_\_

Do you consent to receiving appointment reminders?  Yes  No

How do you prefer to receive reminders?  Phone  Email

Employer or School Name: \_\_\_\_\_

Emergency Contact (Name/Phone/Relationship) \_\_\_\_\_

**Responsible Party** *(If Patient is a minor -- under 18 years of age)*

Name (First, MI, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Is it okay to leave confidential information in a voicemail at the above numbers?  Yes  No

Email Address: \_\_\_\_\_

Employer or School Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Other Parent/Guardian Name: \_\_\_\_\_

**Insurance Information** *(Complete this even though we will copy your insurance card)*

Insurance Company: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Secondary Insurance Information** *(Complete this even though we will copy your insurance cards)*

Insurance Company: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**I have reviewed the above information and it is true and correct to the best of my knowledge.**

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

## Patient History

Patient Name: \_\_\_\_\_ Therapist: \_\_\_\_\_

Name of Person Completing This Form: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Primary Care Physician (PCP): \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Name of Psychiatrist (If Applicable): \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Check any of the following that have been problematic over the last 6 months:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcohol Abuse                    | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Panic Attacks          |
| <input type="checkbox"/> Allergies to Food or Medications | <input type="checkbox"/> Financial Problems    | <input type="checkbox"/> Physical Assault       |
| <input type="checkbox"/> Amnesia/Blackouts                | <input type="checkbox"/> LGBTQIA+ Issues       | <input type="checkbox"/> Problems with Children |
| <input type="checkbox"/> Anger Problems                   | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Separation/Divorce     |
| <input type="checkbox"/> Anxiety                          | <input type="checkbox"/> Heart                 | <input type="checkbox"/> Sexual Assault         |
| <input type="checkbox"/> Bowel                            | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Sexual Problems        |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Lack of Energy        | <input type="checkbox"/> Shyness                |
| <input type="checkbox"/> Concentration Problems           | <input type="checkbox"/> Lack of Motivation    | <input type="checkbox"/> Sleep Problems         |
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Lack of Self-Control  | <input type="checkbox"/> Stomach                |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Legal Problems        | <input type="checkbox"/> Substance Abuse        |
| <input type="checkbox"/> Dizziness/Fainting               | <input type="checkbox"/> Loneliness            | <input type="checkbox"/> Suicidal Thoughts      |
| <input type="checkbox"/> Eating Problems                  | <input type="checkbox"/> Loss of Family Member | <input type="checkbox"/> Ulcer                  |
| <input type="checkbox"/> Educational Problems             | <input type="checkbox"/> Marital Problems      | <input type="checkbox"/> Unhappiness            |
| <input type="checkbox"/> Epilepsy                         | <input type="checkbox"/> Memory Problems       | <input type="checkbox"/> Weight                 |
| <input type="checkbox"/> Excessive Energy                 | <input type="checkbox"/> Muscle/Joint          | <input type="checkbox"/> Work/Career Problems   |
| <input type="checkbox"/> Excessive Worrying               | <input type="checkbox"/> Nightmares            |   |
| <input type="checkbox"/> Extreme Fears                    | <input type="checkbox"/> Overtiredness         |   |
| <input type="checkbox"/> Other _____                      |  |   |

Marital Status:  Single  Married  Divorced  Separated  Widowed  Domestic Partner

Who is currently living with you? \_\_\_\_\_

Gender Identity:  Woman  Man  Other: \_\_\_\_\_

Have you had any major illnesses/surgeries/injuries/hospitalizations  No  Yes, list incident and date(s): \_\_\_\_\_

Do you have any medical issues? Currently or historically?  No  Yes, please describe: \_\_\_\_\_

Have you previously received any type of mental health services (therapy, psychiatric care, etc)?  No  Yes

Have you ever been hospitalized for psychiatric reasons?  No  Yes, list incident and date(s):\_\_

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Have you ever attempted suicide?  No  Yes, list incident and date(s):\_

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Have you ever engaged in self-harming behaviors?  No  Yes, please describe:\_

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Have you ever had homicidal thoughts?  No  Yes, please describe:\_\_\_

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Has your psychiatric condition ever led to any legal problems?  No  Yes, please describe:\_\_\_\_\_

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Are you currently taking any prescribed medications?  No  Yes, please list medication and dosage:

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General Health & Mental Health Information:

1. How would you rate your current physical health?

Poor  Unsatisfactory  Satisfactory  Good  Very Good

Please list any specific health problems you are currently experiencing: \_\_\_\_\_

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2. How would you rate your current sleeping habits:

Poor  Unsatisfactory  Satisfactory  Good  Very Good

Please list any specific sleep problems you are currently experiencing: \_\_\_\_\_

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3. How many times per week do you generally exercise: \_\_\_\_\_

What types of exercise do you participate in: \_\_\_\_\_

4. Please list any difficulties you experience with appetite or eating patterns: \_\_\_\_\_

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5. Are you currently experiencing overwhelming sadness, grief, or depression?  No  Yes, if so, for approx. how long?

\_\_\_\_\_

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?  No  Yes, if so, when did you begin experiencing this? \_\_\_\_\_

7. Do you drink alcohol more than once a week?  No  Yes

8. How often do you engage in recreational drug use?  Daily  Weekly  Monthly  Infrequently  Never

9. Have you ever abused alcohol, marijuana, or illegal substances?  No  Yes, please describe.

\_\_\_\_\_

10. Are you currently in a romantic relationship?  No  Yes, for how long? \_\_\_\_\_

a. On a scale of 1-10 (10 being the best), how would you rate your relationship? \_\_\_\_\_

b. Is your relationship having any difficulties? If so, please describe: \_\_\_\_\_

\_\_\_\_\_

11. What significant life changes or stressful events have you child experienced recently:

\_\_\_\_\_

\_\_\_\_\_

#### Family Mental Health History:

1. Have any family members participated in counseling?:

Mother  Father  Sisters  Brothers  Grandparents

2. Have any immediate family members experienced the following? Check all that apply.

Alcohol/Substance Abuse  Anxiety  Depression  Domestic Violence  Eating Disorders  Obesity

Obsessive Compulsive Disorder  Schizophrenia  Suicide Attempts

Does your family have any additional psychiatric history?  No  Yes, please describe: \_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Please describe who raised you during childhood and adolescence:

\_\_\_\_\_

\_\_\_\_\_

4. Please describe any problematic childhood behaviors:

\_\_\_\_\_

\_\_\_\_\_

5. Were there any stressors in your childhood family? If so, please describe them.

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6. Who is your current support system?

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Additional Information:

1. Are you currently employed?  No  Yes

If yes, what is your current employment situation and for whom do you work?

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Do you enjoy your work? Is there anything stressful about your current work?

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Have you ever been fired from a job?  No  Yes, please describe why:

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What mental health impediments have made it more difficult for you to do well at work?

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2. Are you currently a student?  No  Yes

If yes, where are you enrolled and what degree/program are you pursuing?

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What is the highest level of education you have completed?

- Less than High School  High School or Equivalent  Some College  Associate Degree  
 Bachelor Degree  Master Degree  Doctoral Degree

Did you ever repeat or skip a grade?  No  Yes, please describe:

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What were or are your grades like?

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Did you receive or are currently receiving any special services such as an IEP?

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3. Do you consider yourself to be spiritual or religious?  No  Yes, if so, describe your faith or belief:

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4. Are there any cultural considerations you would like for us to consider in your care?  No  Yes, please explain:

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5. What would you like to accomplish out of your time in therapy?

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6. What other information would you like your therapist to know?

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## Financial Procedures and Agreement

In order to help eliminate any misunderstandings with regards to your financial responsibilities, the following policies and procedures will be adhered to.

### Psychological Services and Costs

| Service  | Fee Schedule |
|--|--------------|
| Initial Diagnostic Interview (90791)                                   | \$200        |
| 60 Minute Therapy Session (90837)                                      | \$175        |
| 45 Minute Therapy Session (90834)                                      | \$160        |
| 30 Minute Therapy Session (90832)                                      | \$120        |
| Psychological Testing (per hour)                                       | \$175        |
| Court Consultation/Appearance (per hour, 2 hour or \$350 minimum)      | \$175        |
| Court Letters/Documentation (per hour, billed in half hour increments) | \$120        |

These charges remain the same whether the treatment is on an individual, couple, or family basis. The psychological testing process and time required varies with the issues/problems to be evaluated, the type of testing instruments to be used and the time required by the psychologist to score and complete a report of the findings. For more information on psychological testing, please visit our website.

**Billing Procedures** - If insurance coverage is available for your therapy/evaluation, the subscriber is required to assign insurance benefits to Family Guidance Centers (FGC). Each responsible party is required to complete the patient information form with accurate and complete information. Failure to provide current and accurate information may result in reimbursement denial by your insurance company. As a service to our clients, we will assist you in completing and filing the insurance claims. Further, a monthly statement will be sent to the address on file for accounts with balances above \$5. Most insurance plans call for a deductible or co-payment then will typically pay a percentage of the costs thereafter. **EACH CLIENT IS REQUIRED TO FULFILL THE DEDUCTIBLE AND THEN PAY THE REMAINING PERCENTAGE OR COPAY ON A SESSION BY SESSION BASIS. ANY OTHER ARRANGEMENTS MUST BE NEGOTIATED AT THE TIME TREATMENT HAS BEGUN, AND MUST BE IN WRITING.** For insurance plans requiring prior authorization, each client is responsible for contacting your insurance company to obtain authorization for treatment. Otherwise, FGC will hold you responsible for professional services rendered. Appointments which are cancelled or not kept by the client without a 24-hour notice will be charged to the client at \$75 per appointment hour. Such charges will not be billed to the insurance company. Therapists may elect to terminate treatment for failure to attend scheduled appointments.

**Delinquent Accounts** - Every effort will be made to obtain reimbursement through your insurance plan. However, it remains your full legal responsibility to assume the financial obligations for our bill should the insurance company deny any part of the claims for services rendered. Accounts are considered past due if no payments have been made for 30 days. Statement of charges sent to you are agreed to be correct and reasonable unless disputed in writing within 30 days. After a 90 day absence of payment, the account is delinquent and will be forwarded to collections. Should it be necessary to resort to a collection agency and/or attorney for the collection of your account, you agree to pay any attorney and collection fees not to exceed 1/3 of the unpaid balance and any court costs incurred in addition to the amount owed.

**I have read and agree to financial responsibilities for entering into counseling with FGC. Your signature below authorizes release of medical information necessary to file your insurance claim(s) and assign benefits to FGC. In the event that a legal collection action is necessary, you authorize FGC or its agent to make a credit investigation, including employment verification.**

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



**General Office Policies**

Please review each policy below and then initial the corresponding box to indicate that you have read and understood the policy.

\_\_\_\_\_ (initial here) **Financial Policies and Cost of Services**

Most insurance companies reimburse a portion of the cost of services. We will assist you as best we can to determine your copay, deductible, or coinsurance amounts and we will automatically file your claim, if accurate and current insurance information is provided. Please note, however, that you are responsible for verifying your insurance benefits, providing any required background or other information to the company prior to payment, and arranging for initial preauthorization of care, if required. Ultimately, you are responsible for your bill, not your insurance company.

\_\_\_\_\_ (initial here) **Records Release, Preparation of Letters or Reports, Non-Emergency Telephone Calls, and other Incidental Activities**

In recent years, healthcare companies have reduced reimbursement rates and limited coverage to face-to-face contact only. Records releases, reports, letters, disability certificates, telephone calls, and many other necessary activities are not covered by your insurance. Charges for these services are calculated based on the time required to complete the activity as shown in the fee schedule below.

\_\_\_\_\_ (initial here) **Cancellation & No Show Policy**

A minimum of **24 hours notice is required for cancellation of appointments**. If this notice is not received or if the patient fails to show for the appointment, the Responsible Party will be charged \$75 for the no show/late cancel appointment. No show or late cancel appointment fees are due immediately.

| Service   | Fee Schedule |
|---|--------------|
| Preparation of <b>non-forensic</b> reports, letters, telephone or other conferences (including all patient or Responsible Party requested telephone contact), chart review, records releases <u>per half hour</u> * | \$40         |
| Court consultation, appearance, or testimony is billed per hour, with a 2 hour minimum. Unless otherwise arranged, estimated costs are due in advance of a court or deposition appearance*                          | \$175        |
| Forensic services such as conferences, preparation of reports, telephone consultation, travel and records review to the court are billed in half hour increments*   | \$120        |
| No Show or Late Cancellation Appointment Fee*   | \$75         |

(\*These services are not covered by insurance)

I have reviewed, understood, and agree to the fees & general office policies above:

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Signature



Psychological Testing & Evaluation Agreement

This agreement is an addendum to the Financial Procedures and Agreement form and is part of the Intake Packet for FGC services.

Psychological Testing and Evaluation (PTE) is a complicated and time consuming process. A full PTE can, on average, range between 8 to 12 hours and depends on the areas of need. These total fees may be less in a tightly-focused assessment in which fewer tests are administered; they can be more in very complicated cases in which many assessment procedures are needed. A full PTE includes: a review of medical and/or school records, relevant consultations with treating professionals, actual testing administration, test scoring and interpretation of data, and report writing. A part of this process is an initial diagnostic interview and a final results review session. All PTEs are unique and sometimes require additional tests beyond the usual protocols. The PTE is typically divided into two separate work sessions of several hours each. If required, a brief progress note can be provided to a treating provider. In most cases, a final written report can be provided within 4 weeks after completion of the PTE. Please note, no specific guarantees are made about the results/recommendations of the evaluation (including diagnoses) or the number of sessions necessary for the PTE to be completed.

For self pay patients, a \$525 partial payment must be paid at the initial testing session. All future testing appointment fees are due and payable at the time services are rendered. The fee for each service noted above is \$175/hour. A credit card on file and authorization form is required for PTE services. Please be advised that any legal or court consultation, witness, or appearance is billed at \$175/hour with a 2 hour court appearance minimum (\$350) to be paid in advance of the court date. No PTE report is released until the account balance is paid in full via cash or credit card. Failure to give proper 24 hour cancellation notice may result in a \$75 charge. It may also jeopardize the ability to schedule any future PTE appointments. Insurance is accepted for the PTE services for the following insurance companies: Anthem, Cigna, Magellan/Medicaid, Optima, and Optum/UBH.

I have read and understand the information on the PTE services and fees.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Psychological Testing & Evaluations Credit/Debit Card Payment Authorization Form

I authorize Family Guidance Centers to initiate charges to my Credit/Debit Card listed below for the total amount due at each psychological testing visit. Charges to my account may vary. 24 hours notice is required for cancellation. Failure to attend a scheduled psychological testing visit can result in a \$75 fee which you authorize to be automatically charged by way of this form. Please discuss any no show charges with your therapist.

If necessary, I authorize Family Guidance Centers to initiate adjustment for any transactions credited or debited in error. This authority will remain in effect until Family Guidance Centers has received written notification from myself to cancel it, allowing 30 days for action on my cancellation notice.

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Parent DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Credit Card Information

Card Type:  Visa  Mastercard  Discover  AMEX  Other \_\_\_\_\_

Cardholder Name (as shown on card): \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date (mm/yy): \_\_\_\_ / \_\_\_\_

CVV2 (3 digit number on back of card): \_\_\_\_\_

Cardholder ZIP Code (from credit card billing address): \_\_\_\_\_

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date



**Release of Information Authorization**

\_\_\_\_\_ I do not wish to release information to anyone but myself

Client Name: \_\_\_\_\_ Client DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Parent DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Client authorizes Family Guidance Centers to disclose the selected information to the following people:**

- 1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_
- 2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_
- 3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**DESCRIPTION OF INFORMATION TO BE DISCLOSED**

Please initial each item that you allow to be disclosed.

- \_\_\_\_\_ Assessment
- \_\_\_\_\_ Progress in Treatment
- \_\_\_\_\_ Diagnosis
- \_\_\_\_\_ Current Treatment Update
- \_\_\_\_\_ Psychological Evaluation
- \_\_\_\_\_ Other \_\_\_\_\_
- \_\_\_\_\_ Presence/Participation in Treatment to include appointment dates and times.

**REVOCATION:** I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Family Guidance Centers' Administration at [contact@familyguidancecenters.com](mailto:contact@familyguidancecenters.com). I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**EXPIRATION:** Unless sooner revoked, this authorization does not expire.

**FORM OF DISCLOSURE:** Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem appropriate and consistent with applicable law and our Privacy Policy, including, but not limited to, verbally, in paper format, and electronically.

**REDISCLASURE:** I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

\_\_\_\_\_  
Client or Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician/Witness

\_\_\_\_\_  
Date



## Phone & Email Contact Consent and Authorization

I, \_\_\_\_\_, with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize Family Guidance Centers staff and therapists or any of its automated systems to contact me via phone or email address (including to my cellular phone by way of phone call, or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items or appointment reminders).

As a patient of Family Guidance Centers, you may request that we communicate with you via unencrypted electronic mail (email). This page will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

Family Guidance Centers will make every effort to promptly respond to your requests for information via email, however, *if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.*

### Risks of using email to send protected health information include, but are not limited, to:

- **Risk of Unauthorized Access by a 3rd Party:** Do you share a computer with your family? Is your email address or access to email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your health information. Despite necessary precautions, email may be sent to the wrong address by either party. Email may be intercepted or altered in transmission by a computer hacker or computer virus.
- **Unique Difficulty in Verifying the Sender:** Email may be easier to forge than handwritten or signed papers. Family Guidance Centers will only send emails to the email address you provide, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.

### **Patient Consent to Unencrypted Email Communications**

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. By signing below, you agree to hold Family Guidance Centers harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

If this Consent and Authorization *applies to someone for whom you are a legal representative, please print their name below, if not please indicate so by populating the blank with N/A.*

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative\*

\_\_\_\_\_  
Date

\*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.



### Telehealth Consent Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

1. I understand that my therapist wishes me to engage in a telemedicine therapy visit.
2. My therapist has explained to me how the video conferencing technology will be used and how it will not be the same as a direct patient/therapist visit.
3. I understand there are potential flaws to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telemedicine therapy visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The information shared will only be on a need to know basis explicitly for billing and scheduling.
5. I have had the alternatives to a telemedicine therapy explained to me, and am choosing to participate in a telemedicine therapy visit.
6. I understand that billing will occur from my therapist under the facility of Family Guidance Centers.
7. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this telemedicine therapy visit. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name



## COVID-19 Agreement Form

We are following the Center for Disease Control (CDC) guidelines to protect the public, as well as our employees, from the COVID-19 pandemic. Please read this document carefully.

It is important to consider that, although insurance reimbursement for teletherapy services may have been mandated during the COVID-19 pandemic, such mandates may no longer be in effect, and teletherapy may no longer be reimbursed by your insurance company.

In order for your therapist to provide you with in-person services, the following protocols must be followed by patients/clients and providers:

- Social distancing requirements must be met, meaning that you must maintain a six-foot distance from others while in offices, waiting rooms, and other areas. Patients/clients and providers will be required to wear face coverings or masks while in the office. If you do not have a face covering, one will be provided to you. Hand sanitizer will be provided at the office entrance. There will be no physical contact with others in the office.
- You agree not to present for in-person services if you have a fever, shortness of breath, coughing, or any other symptoms associated with COVID-19, or if you have been exposed to another person who is showing signs of infection or has confirmed COVID-19 within the past two weeks.
- If you are bringing a child or other dependent in for services, you agree to ensure that both you and your child/dependent follow all of these protocols.
- As COVID-19 regulations continue to evolve, your therapist may become legally required at some point to disclose that you and your therapist have been in contact, especially if either of them were to test positive or show signs of COVID-19 infection. If your therapist is legally compelled to disclose information, they will inform you and will only provide the minimum necessary information (e.g., your name and the dates of contact) required by law.
- We remain committed to following state and federal guidelines and to adhering to prevailing professional healthcare standards to limit the transmission of COVID-19 in our offices. Despite our careful attention to sanitization, social distancing, and other protocols, there is still a chance that you will be exposed to COVID-19 in our office. If, at any point, you prefer to stop in-person services or to consider transitioning to remote services, please let your therapist know.

Individuals that are vaccinated are still expected to follow these guidelines while receiving services from Family Guidance Centers. By signing below, you acknowledge that you understand that there is still a potential risk of exposure and that you agree to follow the safety protocols outlined above in order to engage in in-person services.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Parent/Guardian Signature (If Patient is a Minor): \_\_\_\_\_

Today's Date: \_\_\_\_\_