Client name: _____ Two Forms of ID copied: ❑

Fee Schedule and Payment Agreement

The Resolve Clinic is dedicated to Resolving barriers to your recovery & to the restoration of relationships. Specializing in Trauma, Process addiction, and eating disorders. We are a Fee-For-Service Provider and do not accept Insurance or Medicaid. **Fees are due at or before the time of service.**

Initial Intake: Application /Needs Assessment/Evaluation - $200
Initial Paperwork includes Personal History Profile, Current Assessment of Functioning, Informed Consent for Services, Legal Consent to Treatment, Level of Care/Counseling Regimen and Recommendations.

Please check the type(s) of service below that you feel will be most appropriate for you.

_____ ***Individual Counseling Sessions:***
45-50 minute individual session - $125

_____ ***Family/Couples Counseling Sessions:***
45-60 minute Family Counseling session - $150
45-60 minute Couples/Marital Counseling session - $150

_____ ***Medication Evaluation***
50-90 minutes - $350

_____ ***Follow-Up***
20-30 minutes - $125

_____ ***Medication Refill*** - $35

_____ ***Group Process Sessions:***
60 minute sessions - $35 (Completed ROI required if receiving counseling services elsewhere)

_____ ***TASK Group Sessions:***
60 minute sessions - $45 (Completed ROI required if receiving counseling services elsewhere)

_____ ***Skills Group:***
90 minute in-person sessions - $50 per person

_____ ***Urine Drug Screenings:*** - $15

_____ ***Intensive Workshop(s):***
26 hours/ 5 days - $2000 per person & $3500 per couple

_____ ***Mini Intensive:***
Sexual Health & Healing Intensive (10 hours/ Weekend) - $775
"Survivors" of Childhood Trauma & Addicted family Systems (10 hours/ Weekend) - $775

_____ ***5 Day "Deep Dive" Intensive:***
Sexual Health & Healing Intensive (26 hours/ 5 Day) - $2000 per Individual or $3500 per Couple

_____***Psychometric Testing/ Sexual Inventories with Clinical interpretation:*** - $200

_____***Emotional Support Animal/Reasonable Accommodations (For housing/travel):***
Clinical Evaluation/Needs Assessment - $200 + Letter - $50 = $250

_____***Additional Services:***
Superbills, Requested Letters, Summary of Service, Disability Paperwork, Case Management, etc. - $125 per hour

Approved by: _____ Date: _____

Intake Audited by: _____ Date: _____

Service Recipient's Registration

Name: (First, Middle, Last) _____

Nick Name: _____ Social Security Number: _____

Date of Birth: _____ Age:____ Gender: _____ Pronoun:_____ Sexuality: _____

Race/Ethnicity: _____ Religion: _____

Mailing Address: _____
_____
Zip Code

Phone: (Home) _____
(Cell)_____
(Work) _____

Email Address: _____

Preferred Method of Contact: _____
Do we have permission to contact you via text message? Y N Voice Message Y N
Do we have permission to contact you via email? Y N

Emergency Contact Name: _____

Relation to Client: _____ Phone: Home_____ Cell _____

Employment Information: I am currently - Employed Unemployed Seeking Employment
If employed, please list the following:
Name of Employer (Company/Business): _____
Date Employed: _____ Current Position/Job Description:_____
Monthly Income: _____

Education: I am currently a student Y N I have completed High School Y N
I have attended college Y N I have a college degree Y N

I am Active Military Y N I am a Veteran Y N

If Client is a Minor (Under the age of 18):
Who has legal custody? Name: _____

Address: _____ Phone: _____
(If Different from Above)

I, the undersigned, have provided accurate registration information (above) to the best of my knowledge. I agree to notify Resolve Strategies immediately if any changes occur to this information.

Client or Guardian Signature Printed Name Date

Informed Consent for Services

Confidentiality:

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "Medical Records Privacy Law," HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA applies to all health care providers, including mental health. Health care providers throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records.

Be informed that the counselors and staff of Resolve Strategies, Inc. guard your privacy to the fullest extent. All communications between the client and therapist are confidential and will not be revealed ***unless required by law***, such as in the case of child or elder abuse, or threats of physical harm to the client or others. I understand that it is NOT the Resolve Clinic's policy to release client progress notes to the client or any public or private entities, even with a signed consent to release information.

Initial: _____

Legal Issues:

Resolve clinicians do not participate in legal proceedings. If they receive a subpoena to appear in court, the client or the legal representative must agree to pay Resolve Strategies $250 per hour plus travel time. Please understand that a subpoena for a counselor to witness in court is always against therapeutic/clinical advisement, as it is likely to harm the client's case. In lieu of a court appearance, the counselor can provide a written Treatment Summary for a fee of $125 per hour.

Initial: _____

Electronic Communications:

While your therapist will take reasonable precautions to protect your confidential information, email, texting & social networking are not completely secure methods of communication. Email and other forms of electronic communications may be used for convenience in regard to scheduling, appointment reminders, homework assignments, follow-up care, or information concerning payment status. It is NOT a way of communicating therapeutic information regarding care or emergency treatment.

I acknowledge that if I use electronic mail to initiate contact with my therapist, that he/she and/or his/her representative has my permission to respond via the originally initiated communication (i.e. text, email, etc.)

Initial: _____

Emergencies:

While our clinical staff strives to be available when needed, please note that they are not on call for emergencies. I understand that, if I have an emergency, I should contact the nearest hospital emergency room or dial 911. I further understand that my listed "Emergency Contact" listed on page 3 will be notified for any medical emergencies or accidents.

Initials: _____

Since Weapons of any kind are NOT allowed in the building, I understand that law enforcement officers required to carry a loaded weapon while on duty must sign a special waiver and it will be kept in their client file.

Initial: _____

Appointments and Payments:

Insurance is not accepted, and clients will be expected to pay for services at the time of their appointments. If clients should choose to submit insurance claims on their own, Resolve will provide receipts for this purpose. Be advised that insurance cannot be billed for late, canceled, or missed appointments.

I understand the fee schedule and payment agreement for Resolve Strategies Counseling Services. I know that I will be expected to pay for missed appointments that are not canceled 48 hours in advance, except in the event of a documented emergency. If my fees are not paid in full for two sessions, I understand that no further sessions will be scheduled until the balance is paid.

Initials: _____

Payment Policy:

The fees listed may be adjusted annually. However, clients will be notified prior to any changes. **Payments are due in full at the time services are rendered.** Cash is the preferred method of payment, but personal checks and credit cards are accepted. There is a $30 charge for all returned checks, and returned checks will result in a "cash only" payment from that time forward. A **$5.00 fee is required for each credit card payment** to cover processing costs. A rescheduling fee of $25 may be applied in the case where an appointment is canceled within 48-hours of the scheduled session, but rescheduled within that same week, (pending clinician availability). This is an alternative solution to paying for a late cancellation and an additional session within the same week. Note: in this situation, clients are expected to pay their session fee and the rescheduling fee ($125 + $25); there is no guarantee that your clinician has availability to accommodate rescheduling within the same week.

A Credit Card Authorization form must be kept in your personal file. I authorize Resolve Strategies, Inc. to store my Credit Card information in the SQUARE and STRIPE systems. This card will be charged for any appointments that you fail to keep without 48-hour cancellation notice, superbills, and any additional case management requests (i.e. Disability paperwork, letters to court).

Appointment Policy:
Counselors schedule all client appointments. When you confirm an appointment with your counselor, you are confirming payment for services. Resolve, therefore, requires that clients provide at least **48-hour notice when canceling/rescheduling an appointment.** Late Cancellations are NOT refundable because you are paying for the counselor's time. Clients who do not show up for appointments, and have failed to call to cancel, will be charged the full fee for those appointments. If you must cancel, please contact your counselor directly. *To maintain active client status, you must be seen at least monthly or you may be subject to be re-admitted as a new client and an updated intake will be required (intake fee will be applied). If you become an inactive client and wish to be scheduled following more than a month's absence, you run the risk of going on your counselor's waitlist or being reassigned.*

***Availability:** Please list times most convenient for you to schedule appointments:

_____

***Preferences:** While we cannot guarantee a certain gender, race, ethnicity, sexual orientation, etc. of your counselor, we try our best to accommodate when possible. Please list any preferences here:

_____
*if you have a specific trauma response to a certain gender, race, ethnicity, sexual orientation, etc. **PLEASE** let us know so we can provide a safe and welcoming environment for all.

Gift Giving Policy:
We encourage and acknowledge the desire of our clients to express gratitude. However, due to our ACA and NASW Code of Ethics, counselors are not able to accept gifts of any kind over $50 from their clients (a cup of coffee is acceptable instead).

I have reviewed the fee and payment guideline listed above. I agree to accept financial responsibility for services provided, as well as for missed appointments that have not been canceled 48 hours in advance.

Client /Guardian Signature ***Printed Name*** ***Date***

Resolve Clinician & Credentials: _____***Date:*** _____

Credit Card Authorization

This form must be filled out even though you may not choose to pay for your appointments with a credit card. (This information will be kept confidential & secure.)

Please provide your credit card information below. This will simplify payment procedures in the event of a missed appointment without notice of cancellation, as well as occasions where an appointment is canceled without 48 hours advance notice. Additionally, this will be used for superbills and additional case management requests. In either event, your credit card payment will be processed at the end of your scheduled appointment. Your acceptance of this policy ensures your payment will always be up-to-date and will be made in a timely manner.

We do not accept HSA or Flex Spending Cards for payment.

If you choose to make your payments by Credit Card instead of cash or check, we must charge an additional $5.00 fee per payment for processing costs.

Print Name: _____

Cost of Session: _____ Counselor: _____

Billing Address: _____

_____

(**Must include Zip Code**)

Phone Number: _____ Email:_____

Type of Card: (Circle One): VISA MasterCard AMEX Discover

Card #: _____

Expiration Date: _____ CVV : _____ (3 digit # on back of card)

Confirm this is not a HSA/Flex Spending account issued by your employer or connected to health benefits _____.

Signature: _____

Please Note: Your signature gives Resolve Strategies permission to bill your card for services provided, and to store your card in Square and STRIPE. This includes charges for "no shows" or cancellations not made within 48 hours of your scheduled appointment time. Flex Spending cards cannot be used as a primary card on file. You may complete an additional credit card authorization form and attach to the intake packet.

Discharge Policy & Attendance:
A decision to discharge and/or transition a client will be based upon any of the following reasons:

- Client requests discharge and/or transition
- Therapeutic services no longer align with client's goals.
- Client requires an increased level of care
- Client is being transferred or transitioning to another agency
- Clinical overlap from supplemental services (conflicting information from multiple providers)
- Client does not uphold attendance regulations
- Failure to adhere to clinical recommendations (i.e., increased level of care, session frequency, 12-Step Programs, IOP) that could result high-risk behaviors
- Communication with client cannot be established or re-established despite continued efforts (i.e., phone calls, emails)
- Client moves out of the state/area
- Client achieves all goals established by client, family, caregiver and/or clinician

Our staff must strictly adhere to regulations concerning missed and rescheduled appointments. Please understand that clients who have habitual cancellations and no-shows are preventing other clients from scheduling during that time slot.

Failure to attend for 2 scheduled sessions in a row (without a call or reschedule request), is considered "non-compliant" and a reason for Discharge. **Initial:** _____

Habitual cancellations and reschedules and/or a pattern of non-compliance are considered reasons for Discharge.
Initial: _____

If a client cannot be reached after 3 attempts to contact within a two week period, they will be discharged.
Initial:
_____

Our commitment to serve you must be matched by your commitment to keep appointments and actively participate in treatment recommendations.

Please know that clinicians will make every effort to reach you before removing you from their caseloads. **Clients that have not been seen in over a month without prior discussion will be discharged and are required to complete another intake appointment before continuing services.** Continuation of services are based on clinician discretion and availability.
Initial: _____

Public Contact:
In order to maintain your confidentiality, your therapist will not acknowledge you in the event you encounter them in public. This ensures that you will never be put in an awkward position, not knowing how to respond. If you would like to initiate an acknowledgment, your therapist will be delighted to respond. They will not be offended if you choose not to do so. While our counselors do not view therapy as shameful or something to be concealed, they understand that discretion is important and your right to privacy will be respected.

I understand that information about therapy sessions will always be kept confidential, even if I choose to engage in a social conversation in public. **Initials:** _____

Legal Consent to Treatment

Service Recipient's Name: _____Birth Date: _____

Social Security Number: _____Phone: _____

Email: _____

Fill out the remainder of this application with your counselor & Initial each section as explained

_____ I have had confidentiality explained clearly to me by a Resolve Service Provider, and I fully understand that my privacy will be protected and respected by Resolve Strategies.

_____ I have had the "limits of confidentiality" explained to me by a Resolve Service Provider, and I fully understand that (as mandated reporters) Resolve Strategies, Inc. is ethically obligated to breach my confidentiality and report to the proper authorities any active intent to harm myself or others, and active/current instances of child abuse or elder neglect.

_____ I have been given the contact information for the Resolve Rights advocate, and I understand that I have an opportunity to schedule a meeting to discuss concerns involving any event in which I feel that my rights may have been violated.

_____ Any notes recorded by the clinician is the sole property of Resolve Strategies, Inc. and the contracted clinician. They are not available for release to the client or any third party. Any requests will be denied. It is our practice to release Superbills and Summary of Services ONLY (with a signed ROI).

_____ I have read the Client Bill of Rights and the Resolve Clinic Crisis Procedure.

_____ I have had Resolve program policies, regulations, and expectations explained clearly to me by a Resolve Service Provider, and I understand the consequences of non-compliance. I agree to abide by/comply with all their policies and safety regulations, and to respect the professional opinions of Resolve counselors and staff.

I have read the above information and voluntarily request counseling services from Resolve Strategies, Inc. I agree with their terms and conditions, and I give my formal consent willingly and without force for Resolve to provide any psychotherapy and/or psychoeducational services that their staff recommends and deems necessary for my treatment. I affirm my understanding of "Informed Consent" and "Restricted Confidentiality."

Signature of Client: _____ Date: _____

For Clients Under the Age of 18: I am seeking services for this minor child to engage in a professional relationship with the counseling staff of Resolve Strategies, and I agree to their terms and conditions.

_____

Signature of Parent/Legal Guardian Printed Name Date

_____

Witness/Resolve Clinician Signature Printed Name Date

Divorce and Custody Cases

Resolve Counselors Do NOT Evaluate Custody Cases
and cannot make any recommendations on custody.

We may elect to see children whose parents are in the process of custody litigation. Due to the sensitive nature of divorce and all potential issues that may arise in such cases, we have very specific policies to which you MUST agree before we enter a counseling relationship.

1. Provided all proceedings have come to a close, we require a copy of the current, standing court order demonstrating custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge. We will need to have contact with the parent who has legal custodial decision-making for medical issues before we see the child for counseling, and will need to obtain written consent for the child to participate in counseling from the legal custodian(s). We prefer to have contact with both parents prior to seeing the child.

2. We ask all clients to waive their right to subpoena our counselors to testify in court. This policy is set in order that we can preserve the efficacy and integrity of the therapeutic process and relationship with you and/or your child. It is our experience that a counselor's appearance in court often damages the therapist-client relationship, and it is our ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of our clients. By signing this agreement, you waive the right to subpoena a Resolve counselor and client records. If you prefer, we will recommend a referral to a therapist(s) who are willing to appear in court.

3. In the event that we are subpoenaed to appear in court despite this waiver- whether we testify or not – we charge the full standard Court Related fee. A retainer of $1,000 is billed and drawn on during the court process. Professional time is billed at $250 an hour. All time dedicated to any court-mandated appearance including but not limited to: preparing documentation, discussions with lawyers and/or a guardian ad litem, affidavits, depositions, wait time spent at the courthouse, time on the stand, and travel will be billed at $250 per hour. Food and lodging will be billed if expenses are incurred in relation to the court case.

I understand these policies and I, and any of my representatives now and in the future, hereby waive any and all rights to subpoena Andrea M. Epting or any Resolve Strategies Practitioners/Contractors.

Printed Name: _____ Signature: _____ Date:_____

Printed Name: _____Signature: _____ Date:_____

Authorization for Release of Information

I sign this form voluntarily knowing that I am authorizing the use or disclosure of my individual identifiable health information as described below. I understand that reports and/or medical records to be released may contain information pertaining to social, educational, psychiatric, drug and/or alcohol abuse diagnoses and treatment, and may also contain confidential HIV/AIDS related information. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Client's Name: _____ SSN: _____ DOB: _____

Organization: _____
(Telephone) (Fax)

Collaborating Individual or
Organization_____
(Telephone) (Fax)

Type of Information that may be released:

_____ Admission Notes	_____Continuing Care Plan	____Court Orders	_____Parole Plan
_____ Assessments	_____ Psychological Evaluation	____Probation Reports	
_____ Educational Evaluations	_____ Psychiatric Evaluation	____ Laboratory Tests/Drug Screens	
_____ School Based Issues	____ Medical Evaluations	____ Police Reports	
_____ Legal Documents	_____ Medical Regimen	____Treatment Plan	
_____ DFCS Investigation	_____Family Relations Report	____ Discharge Summary	
_____ Client Attendance	_____Client Progress	____ Client Billing	

This is needed: ____To provide ongoing care/treatment ____Other: _____

This authorization will expire when this case is closed by Resolve Strategies, Inc.

I understand that my healthcare and payment for my healthcare will not be affected by my signing this form. I understand that I may see and copy the information described on this form. I understand that information disclosed in this request about substance abuse treatment is disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information unless such disclosure is permitted by the written consent of the person to whom it pertains, or as otherwise permitted by (42 CFR Part 2). A general authorization for release of information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may revoke this authorization at any time by notifying Resolve Strategies, Inc. in writing, but that it will not affect my actions taken before the revocation.

I have read and understand the above statement and do hereby voluntarily consent the disclosure of the information and/or medical records (including alcohol/drug abuse records) to those persons/agencies named above. I hereby release Resolve Strategies, Inc. of liability arising from the release of this information. If this release concerns a minor, I certify that I am legally authorized to provide consent.

Client or Representative Signature: _____Date: _____
Printed Name: _____ Relationship to Client: _____
Witness: _____ Date:_____

Organization:
Resolve Strategies, Inc.
5 Executive Circle, Savannah, GA 31406
Phone: 912-507-8576 | Email: resolvestrategies.llc@gmail.com

Consent for TeleMental Health Services

Introduction to TMH Services:
TMH services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable therapists to provide services to individuals who may otherwise not have adequate access to care. TMH may be used for services such as individual, couples, or family therapy, follow-ups, and trainings/education in a group setting. TMH is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are fairly minor depending on the needs of the client and the care with which the technology (cell phone, computer, etc.) is utilized. It is important that both the client and the counselor be located in a private place during their sessions, and that the security of their technology be up-to-date with appropriate security protection.

Consent for TMH Therapy

Client's Name: (Please Print): _____

Email Address: _____

Location/Address from which TMH Services will be Received: _____
_____

Phone Number and/or Serial # of mobile Device being used: _____

I understand that my mental health counselor is offering to engage in TMH services via electronic communication, and that this type of therapeutic session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand that TMH has potential disadvantages and risks which include interruptions, unauthorized access, and technical difficulties.

- Information transmitted may not be sufficient (e.g., poor sound or resolution of images) to allow for appropriate treatment such as play therapy or EMDR.
- Delays in treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information. However, security measures will be taken to prevent a breach of privacy.

I understand that all the "Informed Consent" policies, presented and agreed to in my Initial Intake, will also apply to my TMH services. These include Confidentiality, Legal Issues, Electronic Communications, Emergencies, Appointments & Payments.

I understand that the client "Bill of Rights" and "Crisis Procedure" presented to me at the time of my Initial Intake will also apply to TMH services. I understand that Resolve Strategies' TMH service is NOT an Emergency Service, and in the event of an emergency, I will use a phone to call 911.
Emergency Plan: My counselor and I have developed an Emergency plan for my file. I understand that in case of serious threat or plan to harm self or others during a TMH session, my counselor will have the police or an ambulance sent to my location and call the following Emergency Contacts:

Name: _____ Phone: _____

Relation to Client: _____

Name: _____ Phone: _____

Relation to Client: _____

Please initial the following statements:

_____ I understand that TMH services are completely voluntary and that I can choose not to do it or not to answer questions at any time. To maintain confidentiality, I will not share my TMH appointment link with anyone unauthorized to attend the appointment.

_____I understand that none of the TMH sessions will be recorded or photographed without my written permission. I understand that the laws that protect privacy and the confidentiality of client information also apply to TMH, and that no information obtained in the use of TMH, which identifies me, will be disclosed to other entities without my consent.

_____ If technical difficulties ensue (audio and/or visual disconnects), we will end the call, wait 5 minutes, and attempt to reconnect. If, at that time, technical difficulties persist, we will reschedule our session.

_____ I understand that I will be expected to pay promptly for invoices emailed to me for the payment of each session. I understand that I can make TMH session payments online with a credit card or mail a check to the PO Box address.

_____ I have had a direct conversation with my counselor about this "Consent for TMH Services" form, and have had all my questions answered regarding the procedure. The information provided by the counselor included technical directions in obtaining remote access for the TMH session.

_____ If the clinician determines that TMH services are contraindicated, the client will be either transferred to in-person sessions or referred to a local provider.

I understand the information provided above regarding TMH Services. I understand that I MUST be located at the address that I provided above at the time of my scheduled session. I hereby give my informed consent for the use of TMH in my care.

Print or type full name of client: _____

Signature of client or person authorized to sign: _____

Relationship of signee to client: _____ Date signed: _____

Please call or email your counselor directly with any questions or concerns you may have.
Mailing Address: PO Box 16026, Savannah, GA 31416

.....

For Office Use Only
This Signed TMH Consent Form was received:

By Whom: _____

When: _____

How: _____

Service Recipient's Mental Health History

Please describe current difficulties in functioning that should be addressed in counseling sessions.

_____

_____

_____

Were you referred here for services? Y N If yes, who referred you? _____

If no - How did you hear about Resolve? _____

Client's **Family History** of psychiatric/substance use problems? If yes, please describe:

_____

_____

_____

Client's **current** primary physician, psychiatrist, therapist, or other specialists:

_____

_____

_____

Client's **past** physician, psychiatrist, therapist, or other specialists:

_____

_____

Client's **Current and Past Medications** and the conditions for which they are prescribed:

_____

_____

_____

Client's Allergies: _____

Medical History: _____

Are you currently experiencing suicidal ideations? Y N
Do you have a history of suicidal ideation? Y N If yes, what year(s)? _____
Number of suicide attempts: _____ Date of attempts: _____

Are you currently experiencing homicidal ideations? Y N
Do you have a history of homicidal ideation? Y N If yes, what year(s)? _____

Are you currently experiencing visual/auditory hallucinations? Y N
Do you have a history of visual/auditory hallucinations? Y N If yes, what year(s)? _____

Note the year of that you received any of the following services:
_____Outpatient Therapy _____Inpatient Therapy _____Residential Treatment
_____IOP (Intensive Outpatient Program) _____ Detox

I, the undersigned service recipient, have reported the above information honestly, accurately, and to the best of my ability. I acknowledge that it is my responsibility to notify Resolve Strategies immediately upon any change to the above information (i.e. medications, hospitalizations, physicians, etc.)

_____

Service Recipient or Guardian Signature Printed Name Date