clarity

# PATIENT INFORMATION FORM

Date

## PATIENT INFORMATION

Patient's Last Name | Patient's First Name | Patient's Middle Name | Suffix | Preferred name

Date of Birth

☐ Male ☐ Female

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another _____

Race: ☐ Caucasian (White) ☐ American Indian ☐ African American (Black) ☐Hispanic ☐ Asian ☐ Multiracial ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Declined Primary Language: _____

Home address: _____ City: _____ State: _____ Zip: _____

Mail to address: _____ City: _____ State: _____ Zip: _____
(If different from home address)

Home Phone: ( ) _____ ☐ This is the primary number for patient.

Cellphone: ( ) _____ ☐ This is the primary number for patient.

Primary Email Address: _____

## EMERGENCY CONTACT (Pediatric Patients, please list someone other than parents/guardians)

Name: _____ Home Phone: ( ) _____ Relation to Patient: _____

## PARENT/GUARDIAN INFORMATION (Pediatric patients only)

**Parent/Guardian 1** (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: _____ _____ _____ _____
Last | First | Middle | Nickname

Date of birth: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Month/Day/Year

Home address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Employer: _____ Work Phone: ( ) _____ Ext.

**Parent/Guardian 2** (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: _____ _____ _____ _____
Last | First | Middle | Nickname

Date of birth: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Month/Day/Year

Home address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Employer: Work Phone: ( ) Ext.

## RESPONSIBLE PARTY

The Responsible Party is the person who is financially responsible for the patient's account and who will receive all account statements to their address.

Last Name | First Name | Middle Name | Relation to Patient

Home Phone: ( ) _____ Cell Phone: ( ) _____
(If different from the patient) (If different from the patient)

Mail to address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Social Security Number:



**THIS IS A TWO PAGE FORM**

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

☐ **Check here if no insurance. Skip to authorizations (below).**

## PRIMARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

**Subscriber**: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Subscriber's date of birth: _____ (Month/Day/Year)

Patient relationship to subscriber: _____

**If address and phone number is same as patient, please indicate same.**

Address: _____ City, State, ZIP: _____ Home Phone: ( )

Insurance co. name: _____ Phone: _____

Policy/Cert #: Group no.: Effective Date:

## SECONDARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

**Subscriber**: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Subscriber's date of birth: _____ (Month/Day/Year)

Patient relationship to subscriber: _____

**If address and phone number is same as patient, please indicate same.**

Address: _____ City, State, ZIP: _____ Home Phone: ( )

Insurance co. name: _____ Phone: _____

Policy/Cert #: Group no.: Effective Date:

## AUTHORIZATIONS

*I authorize evaluation and treatment and I authorize release of information for insurance/medical purposes concerning evaluation and/or treatment serivces provided to me by Clarity, Inc. I hereby also authorize payment from my insurance company to Clarity, Inc. for services rendered. In addition, I authorize audio recording for the purpose of accurate scoring during the provision of evaluation services.*

Signature _____ Relation to Patient _____ Date _____

## ACCEPTANCE OF PAYMENT POLICIES AND FINANCIAL RESPONSIBILITY

*I understand that some services provided by Clarity, Inc. may not be covered by my insurance and that I will be responsible for any amount not covered by my insurance at the time of service. I understand that it is my responsibility to notify Clarity, Inc. if my insuranve coverage changes and that I will be financially responsible for any noncovered services. I understand that Clarity, Inc. will collect all applicable copays, deductibles, coinsurance, and fees for services not covered by my insurance at the time services are rendered.*

*If a deposit is required for scheduled services I understand that if I cancel the appointment(s) within (2) weeks of the appointment(s) and choose not to reschedule the appointment(s), the deposit will be forfeited. This policy does not apply to appointments that must be rescheduled due to illness or family emergency. I further acknowledge that only one reschedule will be allowed before my deposit is forfeited (this does not apply if Clarity, Inc. has to reschedule the appointment).*

Signature _____ Relation to Patient _____ Date _____

## LATE CANCELLATION AND NO-SHOW POLICY

*I understand that if for any reason I am unable to keep a scheduled appointment, I must contact Clarity at least 24 hours in advance at **(864) 331-1400** to cancel or reschedule. If **two** appointments (in any six-month period) are missed or cancelled with less than 24 hours' notice, Clarity will reschedule the appointment **after** a six-month waiting period from the time of the missed appointment.*

Signature _____ Relation to Patient _____ Date _____



Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

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# Privacy Practices and Authorization for Disclosure of Medical Information

*The privacy of your medical information is important. We will only share information about the services you receive at Clarity, Inc. with person(s) you designate and via the mean(s) you specify. This authorization shall be in enforce for six years, until the patient reaches the age of majority (18 years of age) or until this authorization is revoked by the patient or the patient's personal representative.*

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

## PATIENT'S VERIFICATION CODE

Clarity, Inc. will verify the identity of a person requesting protected health information. Please provide a word/phrase that Clarity, Inc. can ask for to verify identity: _____

## SHARING INFORMATION WITH OTHERS

**Please CHECK the information below that you authorize Clarity, Inc. to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.**

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

_____ Name of person that has permission to receive the above patient information _____ Relationship to Patient

_____ Name of person that has permission to receive the above patient information _____ Relationship to Patient

## COMMUNICATION BY PHONE

I authorize Clarity, Inc. to leave a voice message on the phone number below regarding: Check ONLY ONE

☐ All Information including appointments, general information, updates, billing etc.

☐ Appointment information ONLY

( ) _____ Phone Number _____ Relationship to Patient

## COMMUNICATION BY EMAIL

Please be aware that email communications can be intercepted during transmission or misdirected. Your use of and authorization for the use of email to communicate Protected Health Information or other information of a confidential nature with Clarity, Inc. indicates that you acknowledge and accept the possible risks associated with such communication. **Please CHECK the information below that you authorize Clarity, Inc. to release about above patient via email and the email address(es) you authorize Clarity, Inc. to send Protected Health Information.**

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

_____ Email Address _____ Name of the account owner for this email address _____ Relationship to Patient

_____ Email Address _____ Name of the account owner for this email address _____ Relationship to Patient

## RIGHTS OF THE PATIENT

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or obtain a copy of the protected health information disclosed as described in this document. I can do this by written notification to the address below.

**I authorize disclosure of the information listed above by the means specified and I have read and received a copy of the Notice of Privacy Practices for Clarity, Inc.**

_____ Signature _____ Relation to Patient _____ Date

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# HIPAA Notice of Privacy Practices

Effective as of April 14, 2003
Revised November 16, 2018
Contact: (864) 331-1400

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

*This Notice of Privacy Practices is not an authorization. The Notice of Privacy Practices describes, how we our Business Associates and their subcontractors, may use and disclose protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (also referred to as PHI) is health information is information about you, including demographic information, that may identify you and that relates to your past present, or future physical or mental health care condition and related health care needs.*

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of Clarity, Inc., and any other use required by law.

**Treatment-** We may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

**Payment-** We may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

**Health Care Operations-** We may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. We may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. We may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business. We may use or disclose protected health information to remind you of your appointment, to give you information about treatment alternatives, or other health related benefits or services. If you do not wish to receive appointment reminders or the information about treatment alternatives, other health related benefits, services, you may notify our office and you will receive no further information.

**Fundraising-** We may contact you for our **own** fundraising activities**.** If you do not want to receive fundraising communication, you may opt-out at any time. Each communication will contain methods to be used to opt-out of further communication. If you opt-out, you will receive no further fundraising communications. If at any time you wish to receive fundraising communication you wish to receive the communication again, you can contact our practice.

## USES AND DISCLOSURE THAT REQUIRE YOUR AUTHORIZATION

The following uses or disclosures require a **valid** authorization as defined by the HIPAA standards.

**Uses or Disclosures for Psychotherapy Notes**- We will require written authorization for most uses and disclosures of psychotherapy notes, where applicable.

**Uses or Disclosures for Marketing Purposes**- We will require an authorization for uses and disclosures of protected health information used in marketing.

**Disclosures for a Sale of Protected Health Information**- We will require an authorization for any disclosures that would constitute a sale of protected health information**.**

For any other use or disclosure, you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

## USES OR DISCLOSURES REQUIRING AN OPPORTUNITY FOR THE INDIVIDUAL TO AGREE OR OBJECT

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

## USES AND DISCLOSURES FOR WHICH AN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT IS NOT REQUIRED

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

**Uses and disclosures required by law-** We may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

**Uses and disclosures for public health activities-** We may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

**Disclosures about victims of abuse, neglect or domestic violence-** We may disclose protected health information about an individual whom We reasonably believes to be a victim of abuse, neglect, or domestic violence.

**Uses and disclosures for health oversight activities-** We may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.
**Disclosures for judicial and administrative proceedings-** We may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.
**Disclosures for law enforcement purposes**- We may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.
**Uses and disclosures about decedents-** We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.
**Uses and disclosures for cadaveric organ, eye or tissue donation purposes**- We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.
**Uses and disclosures for research purposes-** We may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.
**Uses and disclosures to avert a serious threat to health or safety**- We may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
**Uses and disclosures for specialized government-** We may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.
**Disclosures for workers' compensation-** We may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

## PATIENT RIGHTS UNDER HIPAA

The following information describes your rights under the HIPAA Standards. We require that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, **except as in the Right of Restriction section.**
**Right of an individual to request a restriction of uses and disclosures-** We will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section. Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service. We will agree to this restriction as long as your payment is honored. If payment is not honored, we are not obligated to continue to abide by the requested restriction.
**Confidential communication requirements-** We will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.
**Access of individuals to protected health information-** An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost-based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.
**Amendment of protected health information-** An individual has the right to ask to have We amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.
**Accounting of disclosures of protected health information-** An individual has a right to receive an accounting of disclosures of protected health information made by us in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12-month period. There will a reasonable cost-based fee for additional requests.
**Right of Breach Notification-** An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

## COPY OF THIS NOTICE

You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

## OUR DUTIES

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
We are required to abide by the terms of the notice currently in effect.
We are required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices with be available and posted at our office(s) and posted on our web site, if applicable.

## COMPLAINTS

If at any time you feel we have violated your HIPAA rights, please contact Clarity's Privacy Officer, 29 North Academy Street, Greenville, SC 29601 or (864) 331-1400, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323. We will not retaliate against any individual for filing a complaint.

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# INFORMED CONSENT FOR EVALUATION AND THERAPEUTIC SERVICES

Client Name: _____ _____ _____ Date of Birth: _____
Last First Middle Month/Day/Year

Welcome to the Psychology and Counseling Department at Clarity. This agreement contains important information about our services and your rights and responsibilities as a client. It is important that you read this document carefully before participating in the evaluation and/or therapeutic services. After you have read this document, please sign your name to accept the terms of this document.

## CONSENT FOR SERVICES

As a legally consenting individual, I agree to permit the clinicians of the Psychology and Counseling Department at Clarity to provide therapeutic services and/or to conduct a comprehensive psychological/psychoeducational evaluation on myself or my child (as applicable).

I understand that psychological and psychoeducational evaluations and therapeutic services are provided by a licensed psychologist, licensed psychoeducational specialist, licensed professional counselor, licensed professional counselor-supervisor, licensed independent social worker-clinical practice, post-doctoral fellow (under the direct supervision of a licensed psychologist), or a trainee (under the direct supervision of a licensed psychologist, licensed psychoeducational specialist, licensed professional counselor, licensed professional counselor-supervisor, or licensed independent social worker-clinical practice) with the requisite training and qualifications for the service they are providing. The services provided by non-licensed providers are provided under the direct supervision of licensed providers. More specifically, a post-doctoral fellow is an individual who has a doctoral degree in psychology and is in the process of completing the year-long supervisory period that is required prior to becoming a licensed psychologist. A trainee/practicum student is an individual who is enrolled in a graduate level program (master's degree or higher) in counseling, social work, clinical psychology or school psychology and is completing supervised field experience for the aforementioned program.

I understand that some psychoeducational services provided at Clarity are available at no cost through the local school district for the purposes of determining eligibility for special education services and that licensed psychoeducational specialists employed by Clarity may not function as an independent evaluator for evaluations paid for by a school district. I understand that participation in evaluation and/or therapeutic services is entirely voluntary, and I or my child can withdraw consent at any time without penalty. However, I understand that Clarity may be unable to provide feedback of the test results if testing is terminated and that I will still be responsible for payment of any testing, scoring, and evaluation time provided up until termination.

## CONFIDENTIALITY

I understand that communication between a client and clinician is protected by both federal and state law. Records of services in the Psychology and Counseling Department are confidential and will not be released in an individually identifiable form without my prior consent unless required by law. I understand that in many situations, Clarity can only release information about services rendered in the Psychology and Counseling Department to others if I sign a written authorization form that meets certain legal requirements imposed by state and federal privacy regulations. Clarity will follow applicable state laws and professional standards in the storage, maintenance, retention, and destruction of clinical records. Please see the HIPAA Privacy Notice, which explains HIPAA and how it applies to your personal health information in greater detail.

I agree that for training purposes, evaluation and/or therapeutic sessions may be observed by supervisors or trainees (such as a post-doctoral fellow). I also authorize the use of clinical case discussion and review of records for the purpose of training or consultation with other providers within Clarity, who are also legally bound to keep the information confidential.

I understand that Clarity must comply with child abuse reporting laws and court mandated rulings regarding release of confidential information or any provision of psychological services. Situations in which Clarity is legally obligated to take action and may reveal confidential information without your written consent include, but are not limited to, the following: filing a report with the appropriate government agency when there is reasonable cause to suspect abuse, abandonment, or neglect of a child under 18 or a vulnerable adult; protective action if it is believed that a client represents a clear and immediate threat to another person or themselves; or receipt of a subpoena from a court proceeding.

## AUTHORIZATION FOR INFORMED CONSENT FOR EVALUATION AND THERAPEUTIC SERVICES

I fully understand and accept the terms of this consent.

_____ _____
Signature of Client (representative or parent/guardian if a minor) Date

_____ _____
Print Name (representative or parent/guardian if a minor) Relationship to Client (if not client)

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# AUTHORIZATION TO REQUEST INFORMATION VIA EMAIL

*The purpose of this authorization is to authorize CLARITY, INC to use email to REQUEST information from the patient, patient's parent(s)/guardian(s), partner/close friend, and/or the patient's school about the patient's typical functioning. These email REQUESTS may contain the following protected information: date of appointment(s), patient's date of birth, patient's name, and patient's gender. Please note that communications FROM CLARITY, INC or TO/FROM its Business Associates are protected by encryption. However, emails sent TO CLARITY, INC by you (the patient or personal representative of the patient) or another party (such as, the patient's school) may be unencrypted as this is not a standard feature of most email providers. Please be aware that email communications can be intercepted during transmission or misdirected. Your use of email to communicate Protected Health Information or other information of a confidential nature to us indicates that you acknowledge and accept the possible risks associated with such communication. This authorization shall be in enforce for 12 months, until the patient reaches the age of majority (18 years of age) or until this authorization is revoked by the patient or the patient's personal representative.*

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

**May CLARITY INC use email to REQUEST the patient (if over the age of 18) or the patient's parent(s)/guardian(s) or partner/close friend (if over the age of 18) complete a questionnaire(s) or provide additional information to the Clarity, Inc?**

☐ No ☐ YES If authorized, please provide the following:

Email Address for Patient (if over the age of 18): _____

Name of Rater 1: _____ Relationship to the Patient: _____

Email Address for Rater 1: _____

Name of Rater 2: _____ Relationship to the Patient: _____

Email Address for Rater 2: _____

**May CLARITY INC use email to REQUEST teacher(s) complete a questionnaire(s)?**

Please note that this authorization **does not** authorize Clarity Inc. to **release** information about the evaluation and/or services received at Clarity Inc. to your child's school. A separate written authorization is required for this.

☐ No ☐ YES If authorized, please provide the following:

Name of Teacher 1: _____ Relationship to the Patient: _____

Email Address for Teacher 1: _____

Name of Teacher 2: _____ Relationship to the Patient: _____

Email Address for Teacher 2: _____

## RIGHTS OF THE PATIENT

- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ (Signature) _____ (Relation to Patient) _____ (Date)



**THIS IS A ONE PAGE FORM**

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

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# TELEHEALTH INFORMED CONSENT

Telehealth services are different experience from in-person sessions and the therapeutic process may be impacted. In clinic sessions remain available if you prefer to continue coming into the clinic to meet with one of our providers in person.

If you would like to participate in telehealth services at Clarity, please read the information below so that you are informed about the risks, limitations, and benefits.

- Confidentiality still applies for telehealth services. No one is permitted to record the session without consent from everyone involved in the telehealth session.
- There are limitations to confidentiality due to the nature of the session and use of technology. As such, we cannot *guarantee* confidentiality. However, Clarity has selected **ZOOM for Healthcare** for providing telehealth and our business associate agreement (BAA) with them allows for end to end encryption and is HIPAA compliant.
- You should confirm with your insurance provider that telehealth (that is, audio and video sessions) sessions are allowed under your plan. If the telehealth services are not a covered service, you will be responsible for the full payment for each session.
- The provider will make every effort to maintain privacy. You should only be within hearing distance of the people participating in the session in order to maintain your confidentiality in your household.
- Telehealth is not best suited for play therapy and/or art therapy. Guardians of a minor are expected to check in with the provider at the beginning of every telehealth session and are to remain available as needed throughout session.
- The provider may determine that due to certain circumstances, telehealth is no longer appropriate and that in-clinic sessions should be resumed.
- The parent or legal guardian will need to provide written consent for telehealth sessions with clients under the age of 18 years old.

The provider will provide you with instructions and/or explain how to use Zoom. You will need a device (such as a laptop, tablet or smartphone) with a camera, microphone and audio (speakers or headphones) during the session. There are ZOOM apps that can be downloaded onto to computer and/or smartphone.

- It is important to be in a quiet, private space that is free of distractions (for example, pets, siblings) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi. In addition, to increase video quality, move your computer as close to your router as possible or use a direct connection (that is, ethernet cable) to you computer.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the provider in advance by phone or email.
- Recording of the sessions is prohibited.
- For pediatric clients, the parent/guardian should remain available during therapy sessions to assist as needed.
- If technical problems are experienced, we may need to either restart or reschedule your session. Please provide a number for your provider to reach you if you become disconnected: _____

In the event of a crisis, you and/or the provider will contact your emergency contact or instruct you to go to the closest emergency room.

Please provide the name of an emergency contact for the client:
Name: _____ Relationship: _____ Phone Number of Emergency Contact: _____

I have read and understood the risks, limitations, and benefits of telehealth. I understand and agree with the terms listed for telehealth and would like to participate in telehealth services as indicated by my signature below.

_____ _____
Signature of Client or Parent/Legal Guardian Date

_____ _____
Client Name Date of Birth

What email address should Clarity use to send ZOOM session information? (Please print clearly)

_____

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**ADULT**
**INITIAL QUESTIONNAIRE**

Date _____

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

Questionnaire Completed by: _____ Relation to Patient: _____

## REFERRAL INFORMATION

Has the patient been to this agency before? □ No □ Yes If yes, when? _____

Primary Care Physician: _____

Referring provider (if different from primary care physician): _____

Who recommended the patient for this appointment?

What are your reason(s) for seeking services at Clarity, Inc. at this time?

When did the patient (or someone else) first notice these concerns, and what did the patient (or someone else) feel led to/caused these concerns?

## FAMILY INFORMATION

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

Occupation: _____ Highest Level of Education Completed: _____

What is the patient's primary language? _____
Is this the patient's native language? □ No □ Yes
If no, what is the patient's native language? _____

## PERSONAL MEDICAL HISTORY

Did the patient have any serious illnesses, injuries (including head) or medical problems **as a child**? □ No □ Yes
If yes, please state: _____

Has the patient had any serious illnesses, injuries (including head) or medical problems **as an adult**? □ No □ Yes

If yes, please state: _____

Is the patient currently being treated for? □ Diabetes □ Heart Condition □ High Blood Pressure

□ Kidney Disease □ Other _____

Please list any medications the patient is currently taking and the reason for taking each medication:



**THIS IS A ONE PAGE FORM**

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**ADULT PSYCHOLOGY AND COUNSELING SUPPLEMENT**

Date _____

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

Questionnaire Completed by: _____ Relation to Patient: _____

## SOCIAL HISTORY

Does the patient have children? □ No □ Yes
If yes, how many? _____ Name and age? _____

Have there been any recent changes or stresses in the patient's family/home? □ No □ Yes
If yes, please describe: _____

Please describe any significant friendships/relationships:

What hobbies/interests/activities does the patient enjoy?

Were there any significant stressors during the patient's childhood (for example, parental divorce, moves, etc.)? □ No □ Yes
If yes, please state: _____

Has the patient experienced any traumatic events as an adult (for example, physical abuse, sexual abuse, domestic violence, etc.)? □ No □ Yes
If yes, please describe: _____

## MEDICAL AND DEVELOPMENTAL HISTORY

How old was the patient's mother when she had the patient? _____ Was the patient adopted? □ No □ Yes
Were there any problems with the patient's mother's pregnancy with the patient? □ No □ Yes
If yes, please state: _____

Were there any problems associated with her delivery with the patient? □ No □ Yes
If yes, please state: _____

Was the patient born prematurely? □ No □ Yes If yes, what was the gestational age at delivery? _____weeks

Did the patient have any early developmental delays (e.g., walking, talking)? □ No □ Yes
If yes, please state: _____

Has the patient received any diagnoses that are developmental (e.g., ADHD, Learning Disorder, Dyslexia, Autism) or psychological (e.g., anxiety, depression) in nature? □ No □ Yes
If yes, please state: _____

Has the patient ever been hospitalized? □ No □ Yes
If so, briefly describe (when, where, reason why): _____



**THIS IS A THREE PAGE FORM**

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

Patient Name: _____ _____ _____ Date of Birth: _____
Last First Middle Month/Day/Year

## EDUCATIONAL HISTORY

What schools did the patient attend from preschool through high school?

Did the patient's parents or teachers have concern for the patient's learning or attention during childhood? If yes, please describe: _____ □ No □ Yes

Did the patient ever repeat a grade? If yes, which and for what reason? _____ □ No □ Yes

Did the patient receive tutoring, have an IEP, or receive accommodations at any time from preschool through high school? If yes, please describe: _____ □ No □ Yes

As a child, did the patient like to attend school? If no, why? _____ □ No □ Yes

What schools has the patient attended since high school? Please state course of study and any degree(s)/certificate(s).

Has the patient received any accommodations and/or tutoring while completing coursework after high school? If yes, please describe: _____ □ No □ Yes

As an adult, does the patient like taking/attending classes? If no, please describe: _____ □ No □ Yes

As an adult, has the patient had to repeat any courses? If yes, please state course(s) and reason(s): _____ □ No □ Yes

What are the patient's <u>academic strengths</u>?

| | | | |
|---|---|---|---|
| □ Reading phonics/decoding | □ Reading Comprehension | □ Reading Fluency | □ Math Calculation |
| □ Written Expression | □ Punctuation/Capitalization | □ Spelling | □ Math Reasoning |
| □ Oral Expression | □ Listening / Following Directions | □ Focus | □ Memorizing |
| □ Perseverance | □ Completing assignments on time | □ Organization | □ Study Skills |

Please check if and when the patient has had ***significant difficulty*** with the following during their lifetime:

| | Preschool | Elementary School | Middle School | High School | Post High School | Current | N/A |
|---|---|---|---|---|---|---|---|
| Reading Phonics/Decoding | | | | | | | |
| Reading Comprehension | | | | | | | |
| Reading Fluency | | | | | | | |
| Math Calculation or Math Reasoning | | | | | | | |
| Oral Expression | | | | | | | |
| Listening / Following Directions | | | | | | | |
| Written Expression | | | | | | | |
| Punctuation/Capitalization | | | | | | | |
| Spelling | | | | | | | |
| Focus | | | | | | | |
| Memorizing | | | | | | | |
| Completing assignments on time | | | | | | | |
| Organization | | | | | | | |
| Study Skills | | | | | | | |



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Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

## SOCIAL, EMOTIONAL, AND BEHAVIORAL HISTORY

Has the patient ever been seen by a psychiatrist, psychologist, or counselor? □ No □ Yes
If yes, briefly describe:_____

Has the patient ever engaged in any self-harming behaviors? □ No □ Yes
If yes, briefly describe:_____

Does the patient have a history of suicidal ideation or attempts? □ No □ Yes
If yes, briefly describe:_____

Does the patient have a history of violence (physical aggression, destruction of property, threats to harm others, etc.)? □ No □ Yes
If yes, briefly describe:_____

Does the patient have a history of involvement with the legal system? □ No □ Yes
If yes, briefly describe:_____

Has the patient or those close to the patient ever had concern for the patient's alcohol consumption or substance use? If yes, briefly describe: □ No □ Yes
_____

## FAMILY MEDICAL HISTORY

| | Is there a family history of the following? | | If yes, list who has/d these concerns |
|---|---|---|---|
| Learning Difficulties | □ No | □ Yes: | _____ |
| Reading | □ No | □ Yes: | _____ |
| Written Language | □ No | □ Yes: | _____ |
| Mathematics | □ No | □ Yes: | _____ |
| Attention Problems | □ No | □ Yes: | _____ |
| Hyperactivity/Impulsivity | □ No | □ Yes: | _____ |
| Anxiety | □ No | □ Yes: | _____ |
| Depression | □ No | □ Yes: | _____ |
| Autism Spectrum Disorder | □ No | □ Yes: | _____ |
| Intellectual Disability | □ No | □ Yes: | _____ |
| Bipolar Disorder | □ No | □ Yes: | _____ |
| Schizophrenia/Delusions/Hallucinations | □ No | □ Yes: | _____ |
| Language/Speech Delay | □ No | □ Yes: | _____ |
| Any Genetic Syndrome | □ No | □ Yes: | _____ |
| Conduct Problems | □ No | □ Yes: | _____ |
| Drug/Alcohol Problems | □ No | □ Yes: | _____ |
| Seizure Disorder | □ No | □ Yes: | _____ |
| Motor or Vocal Tics | □ No | □ Yes: | _____ |
| Hearing Loss | □ No | □ Yes: | _____ |
| Visual Problems | □ No | □ Yes: | _____ |
| Muscular Problems/Weakness | □ No | □ Yes: | _____ |
| Other (please specify) | □ No | □ Yes: | _____ |

**Please share any additional comments or concerns you have (or attach additional relevant information such as, previous evaluations)**

_____

_____

_____

_____



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