



INTAKE FORM

Please note: information you provide here is protected as confidential information.

Name (& preferred pronouns): _____

Address: _____

Cell Phone: _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

I acknowledge that Curis Functional Health may use email and cell phone to coordinate care and cannot protect my confidentiality from the cell phone and email providers.

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Name of parent/guardian (if under 18 years): _____

Emergency Contact name & relationship: _____

Emergency Contact Phone Number: _____

How did you hear about us? _____





GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Marital Status:

- Never Married Domestic Partnership Married
 Separated Divorced Widowed/Widowered

Brief reasoning for seeking counseling: _____

Are you currently experiencing overwhelming sadness, grief, or depression?

- Yes
 No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

- Yes
 No

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain?

- Yes
 No

If yes, please describe: _____





LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Mental health professionals will not share written/verbal information about the client/legal guardian to anyone outside session except in the exceptions outlined below:

Duty to Warn and Protect

If a client discloses intentions/plans to harm themselves/someone else, the mental health professional is required by law to report such information to the appropriate legal authorities, victims, & family.

Abuse of Children and Vulnerable Adults

Mental health professionals have an obligation to protect children, the elderly, or otherwise compromised adults who cannot protect themselves. Should a client state, suggest, or imply that s/he is abusing a vulnerable population, is being abused, is in danger of abuse, the professional is required by law to report the information to the appropriate social services & legal authorities for further investigation. I understand that suspected physical, emotional, or sexual abuse is enough to trigger the professional's duty to report.

Prenatal Exposure to Controlled Substances

Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship/Sponsorship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. In the event that someone other than the client is paying for service, they have the right to dates of service, attendance, & a yes/no answer as to whether the client is using the time appropriately.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.





Digital Media

I understand that the mental health professional cannot protect my confidentiality from whatever I put into writing myself, as well as from non-HIPPA compliant communication providers, such as Google, AT&T, etc. as well as other digital breaches.

Case Consultation

Mental health care professional may consult with or receive supervision from other health professionals regarding the case to ensure the highest and best quality of care for the client. Mental health care professional will make best efforts to protect the identity of the client.

I agree to the above limits of confidentiality and understand their meanings and ramifications. The counseling relationship is intended to be a healing and supportive environment where you can explore issues and concerns. As a counselee I understand that I am a vital part of the overall treatment process and that this process may produce strong and difficult emotions in regard to personal issues. I consent to the mental health treatment knowing that if I need to file a complaint or grievance, I can do so with the LPC board at 1-800-821-3205 if I feel I have been mistreated.

Signature

Printed Name

Date





Court Action Policy and Fees

Clients are discouraged from having their mental health care provider/Curis Functional Health subpoenaed or having to provide records for the purpose of litigation. Mental health care providers are trained to work with clients from a non-adversarial position, not forensically, and do not have the expertise to appear in court. Forensics is an area of clinical specialization and we are able to provide recommendations for such outside services.

Even though you are responsible for the testimony fee, it does not mean that the testimony of the mental health care provider will be solely in your favor. S/he can only testify to the facts of the case and her/his professional opinion.

If the mental health care provider is to receive a subpoena then the attorney or office staff will need to call the office and set up a time for the subpoena to be served during office hours. A minimum of 14 days notice of any Court appearance is required so that schedule changes for clients can be made within a reasonable time frame.

Please note: if a subpoena is received without a minimum of 14 days notice there will be an additional \$500 express charge.

Court action fees are as follows:

1. Correspondence & Letter of Opinion: [REDACTED] \$300 per hour (billed in 15-minute increments)
2. Preparation Time: [REDACTED] \$300 per hour (billed in 15-minute increments)
3. Phone Calls: [REDACTED] \$300 per hour (billed in 15-minute increments)
4. Travel to court [REDACTED] \$300 per hour, minimum 1 hr each way [REDACTED]
5. Depositions [REDACTED] \$300 per hour
6. Minimum charge for court appearance \$1500.00 ≤ half day \$3000 for full day

Attorney fees: I, the client, agree to pay all attorney's fees and costs that are incurred by the mental health care provider & Curis Functional Health as a result of any court action. Reimbursement is due in full at time of appearance.

Retainer: A retainer of \$1,500 is due within 48 hours of subpoena. The remainder of the costs will be billed at the court appearance and will be due upon receipt the same day.





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If the mental health care provider is subpoenaed and the case is reset with less than 72 hour notice prior to the beginning of the day of the scheduled subpoena and or testimony is not given, then the client will be billed \$1500.

Bills for court related actions are presented to clients on a weekly basis and payment is expected upon receipt. A zero balance will need to be kept at all times.

Signature

Printed Name

Date





**PATIENT AUTHORIZATION
For Use And Disclosure Of Protected Health Information**

I _____, hereby authorize Curis Functional Health to:

Circle One: Obtain information from **OR** Disclose information to

Name / Facility: _____

Mailing Address: _____ Phone / Fax: _____

The following specific protected health information: ___ Diagnostic Assessment ___ Psychological Evaluation
___ Treatment Plan ___ Progress Notes ___ Other ___ All as needed

For the purpose of: ___ Verbal Communication ___ Treatment at Curis ___ School Assistance ___ EAP ___
Coordination of Care ___ Payment/billing ___ Utilization Review ___ Other: _____

I understand that this authorization is valid until ___/___/___ or until stated in writing by patient/guardian.

I expressly acknowledge that this authorization is voluntary. The following is/are other criteria or limitations that I make regarding this authorization:

I understand that the office _____ will _____ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. I understand that this authorization may be revoked by the authorizer, in writing, at any time. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form. I understand that I may see and copy the information described in this form if I ask for it and that I will get a copy of this form after I sign it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

This authorization is valid as of ___/___/___, the date I have signed below.

Name of Individual (Printed) _____ Signature _____

DOB _____

Signature of Legal Guardian/Attorney Requesting Records: _____





Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Federal law requires that we obtain your written acknowledgement of receipt of the Notice of Privacy Practices. Please sign or initial below.

I acknowledge that I have received the Notice of Privacy Practices.

Patient Name (Print)

Patient Signature

Patient Date of Birth

Legal Representative Name (if patient is unable to sign) (Print)

Legal Representative Signature

Date: _____





Teletherapy Consent to Treatment

I, _____(client) hereby consent to engage in teletherapy with a Curis Functional Health Provider. I understand that “teletherapy” includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In Texas mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.
3. You understand that this teletherapy occurs in the state of Texas, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the clinician in his/her Texas office. It is the responsibility of you, the client, to inform if this is not the case, in which teletherapy services cannot be offered.
4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my mental health clinician, my condition may not improve, and in some cases may even get worse.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. Teletherapy is not recommended for children under the age of 12 given that the services are often interactive and play based. However, children can vary in levels of emotional development and maturity, therefore appropriateness can be evaluated for children in the 10-13 age range.
8. I accept that teletherapy does not provide emergency services. During our first session, the clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or





making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

9. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure, and (5) I should show up to therapy dressed appropriately, as if I were being seen in office.

10. I understand that while email may be used to communicate with the clinician, confidentiality of emails cannot be guaranteed.

11. I agree that my telehealth session happens live and will not be recorded, reproduced, or published. I understand that misuse and or mismanagement of my session by recording it compromises my own integrity and could bear significant damages to the clinician. Should this occur, I bear sole responsibility for these actions, including but not limited to legal fees, damages, etc. I waive the right to confidentiality under these circumstances.

12. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand, and agree to the information provided above.

Client (or Guardian's) Signature _____

Date _____





Late Cancellation / No-Show Policy

Session times are reserved exclusively for me, and I understand that if I cancel a session with **less than 24 business hours' notice**, or do not show for my appointment time, I will be charged \$130 - OR – (the Therapist's full hourly Cash-Pay rate for the session). Business days are Monday through Friday, except holidays. Please note that for Monday appointments, an early cancellation would occur the Friday prior. For example, a 3pm Monday appointment must be cancelled by 2:59pm on the prior Friday to prevent a late cancellation charge. This charge does not apply to those on government health insurance plans.

There is no exception to this policy, even in the event of personal illness or emergency. In the event of contagious illness, I understand and agree that I will not come to the office despite the late cancellation policy. My therapist may be willing to see me via telehealth in this case. Please inquire about this as an option.

If the card is declined, payment isn't processed, or the charge is disputed - I understand that I will not be allowed to carry a balance and my fee must be paid prior to rescheduling. If unresolved, this matter will be turned over to our financial team and may be subject to being sent to collections.

Signature _____ Printed Name _____ Date _____

Curis Functional Health • klitwiler@gocuris.com • (817) 453 - 0430
221 Regency Pkwy, Unit 101 • Mansfield, TX 76063
GoCuris.com





Credit Card Authorization Policy & Signature Form

This form authorizes Curis Functional Health to keep my credit card on file and manually charge the fee for service to this credit card number in the event that:

- (a) Payment was not rendered at time of service
- (b) I am not present to pay for my minor child at the time of service
- (c) Therapist provides consultation outside of sessions (billed per 15 minutes)
- (d) I missed my scheduled appointment
- (e) I cancelled with less than or equal to 24 hours of notice
- (f) I'm on a therapy payment plan, in which case debits will be made on the agreed upon dates
- (g) My account has an outstanding balance and has been delinquent for 10 business days

I, the undersigned, have read and agree to the credit card authorization policy.

Client Signature
Date

Printed Name

Card Type: VISA

MC

AMEX DISC

OTHER

Card Number: _____

Expiration Date: _____

3 Digit Code on the back of Card: _____

5 Digit Billing Zip Code: _____

Name of Credit Card Holder: _____






Insurance/Billing Information

Insurance Policyholder: _____ DOB: _____ Relationship To Patient: _____


Insurance Member ID#: _____

I understand it is my responsibility to keep my insurance information current to prevent billing errors and or delays.  _____ (initials)

Communication

I agree that Curis may communicate with me via:

- Phone _____
- Email _____
- Text _____

I understand that these forms of communication could compromise my confidentiality and accept that risk.
 _____ (initials)





Curis Functional Health is an Integrated Wellness Center

At Curis, we believe that the body is an interconnected system that is best addressed as a whole. Your health is our top priority!

Please check all areas of interest so we may best serve your health needs:

_____ **I'm interested in scheduling an appointment to see a Curis chiropractor.**
Chiropractors help with spinal alignment, overall nervous system function, back pain, neck pain, headaches, bulging/herniated disc and much more.

_____ **I'm interested in making an appointment with a Mental Health professional**
Anxiety, depression, ADD, relationship issues, stress management, parenting, trauma relief, anger management, childhood challenges, teen issues, etc.

_____ **I'm interested in scheduling a FREE Consult with a Curis Dietitian, Nutritionist, or Weight Loss Coach**
Our DNA-based metabolic program removes the guesswork and provides you with a personalized, sustainable plan for weight loss and control. The average client loses 20+/- pounds in the first 40 days! Coaching, support and accountability helps you achieve your goals big or small - according to YOUR genetics.

_____ **I'm interested in scheduling a consultation to discuss adding supplements to _____ enhance my overall health.**
Brain optimization, digestive issues, immune support, allergy relief, stress management, sleep optimization, pain relief, anti-inflammatory responses, joint and disc support.





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SAMANTHA NORTON
NPI: 1982385001
Overland Park
15050 Antioch Rd
Overland Park, KS 66221
(913) 897-6717

Good Faith Estimate

Patient Name:	Date of Birth:
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Estimated Services and Items		Date of Appointment	1/1/2023- Recurring weekly	
Description	Diagnosis Code (ICD-10 Code)	Service Code (CPT)	Quantity	Expected Cost
Initial Intake session or Parent session		90971	P	\$180
45 Minute Therapy Session		90834	weekly	\$180
15 Minute session extension			As needed	\$60
15 Minute outside of session consultation			As needed	\$60
Work completed outside of a formal session will be billed at a rate of \$360/hour in 6 minute increments. (texting, emailing, phone contact, written communication, treatment summaries, calls with attorneys, teacher/school calls, FMLA paperwork, etc.) Courtroom testimony estimates are not included in this Good Faith Estimate.			As needed	\$360/hr billed in 6-minute increments
P - Primary Service (initial reason for visit) C - Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)	Total Expected Charges			\$ 9,360.00
	Date of Good Faith Estimate:			9/1/2023





Disclaimers:

*There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

*The information provided in this good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time this good faith estimate was and actual items, services, or charges may differ from the good faith estimate.

*You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are \$400 more than the expected charges included in the good faith estimate and the dispute is initiated within 120 days after the date of the bill for the items or services. To start the process, you may contact us at the phone number or address listed above to let us know the billed charges are higher than the Good Faith Estimate. You can ask us to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services within 120 calendar days (about 4 months) of the date on the original bill and if the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises.

*This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

Signature: _____

Date: _____

