CLIENT INTAKE FORM

Primary Client's Name Birthdate Age Gender Relationship Status

Secondary Client's Name Birthdate Age Gender Relationship Status

Primary Client's Address City, State Zip Code

Primary Employer's Name Occupation

Primary Phone Number Secondary Phone Number

Primary Email Address Secondary Email Address

How did you hear about us? Type of Therapy Seeking

PRIMARY INSURANCE CARRIER

Policy Holder's Name Date of Birth Relationship to Insured

Marital Status Employer Name Occupation

Insurance Company Name & Address (City, State, Zip Code) Insurance Phone

Group Name & Number Plan Number ID Number Effective Date

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM OR PAYMENT OF MEDICAL BENEFITS TO PROVIDER FOR SERVICES DESCRIBED.

Primary Client Signature Date

CENTER FOR REVOLUTIONARY RELATIONSHIPS

CONSENT FOR TREATMENT- PROFESSIONAL SERVICES AGREEMENT

Welcome to my practice of **CENTER FOR REVOLUTIONARY RELATIONSHIPS (CRR).** The document **(Consent Agreement)** contains important information about my professional services and business policies. It also contains summary information about the **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).** This is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (The Notice) for your use. The Notice, which follows this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the beginning of the treatment process. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions about the procedures at that time. When you sign this document, it will also represent an agreement between us.

CLIENTS RIGHTS

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from our clinical record is disclosed to others: requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complains you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement the attached Notice form, and my privacy policies and procedures.

PSYCHOTHERAPUETIC SERVICES/RELATIONSHIP

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. In order for the therapy to be most successful, you will have to work on the issues we talk about at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. The benefits include renewed relationships, effective communication and problem-solving skills, creative solutions to specific problems and significant improvement of feelings of distress. There are no guarantees of what you will experience. Our initial session will involve an assessment of your psychosocial history as well as a discussion of the objectives

and goals you desire to achieve in therapy. I will be able to offer you some recommendations of what will bring the most immediate relief to your current emotional or relational issues you presented for therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures or do not agree with something I have said, please bring them up so we can discuss them as they arise. If you do not believe we have a good therapeutic "fit", I will be happy to assist you in meeting with another therapist who may be able to meet your needs more satisfactorily. If at any time, I feel a discomfort, lack of safety, therapeutic fit, or uncooperativeness during our therapy sessions, I have the right to dismiss you from the therapy session and premise. Therefore, the therapeutic relationship would terminate.

If I am seeing you as a conjoint marital couple, there will be times when you may be asked to be seen individually. If this occurs, please be aware that the content of the individual sessions will be held in the strictest confidence and no information will be discussed with your mate/partner either in the individual or conjoint session unless given permission by you to disclose this information salient to the therapeutic process. Please note that decisions regarding your relationship are solely based on your choices as a result of the therapeutic process. I am a facilitator in this process to make suggestions in order to help you arrive at your own decisions. Therefore, I cannot be held accountable for any choices made by one mate over the other in conjoint therapy.

APPOINTMENTS FOR MINORS

At the first appointment for a minor, at least one biological parent must be present and bring a photo ID. CRR will need to match the signature on the ID with signatures on paperwork. CRR is ethically bound to verify a minors' biological parents/guardian. In the case of divorced parents, I may need to review the divorce decree/parenting plan, to discern if one or both parents have the right to make the decisions regarding your child's mental health treatment. If your child is the primary client, both parents have access to your child's treatment process and records unless there is a court order blocking one or both of the parents access to this information. Moreover, both parents would each control the child's privilege and anything said in the sessions will be available to either parent. Minors, 14 years or older, may seek therapy on their own behalf without their parents' knowledge. The therapy must last no longer than either 30 days or six sessions, whichever is less. If there is substantial probable harm to the child or others, I must talk to the child and then report this information to their parents.

CANCELLATION POLICY

I understand that regular attendance will provide the maximum benefits, but I am free to discontinue treatment at any time. If I decide to do so, I will notify Dr. Padula at least two weeks in advance so that effective planning of my continued care and be implemented. **I WILL NOTIFY Dr. Padula 24 HOURS IN ADVANCE IF I WILL BE UNABLE TO ATTEND ANY SESSION. IF I FAIL TO MAKE SUCH NOTIFICATION, I WILL BE CHARGED THE FULL AMOUNT OF THE SESSION. I WILL BE SOLELY**

RESPONSIBLE FOR THESE CHARGES. I UNDERSTAND I CAN CALL CRR 24 HOURS/7DAYS A WEEK AND LEAVE A MESSAGE TO CANCEL AN APPOINTMENT.

CONFIDENTIALITY POLICY

I further understand that conversations with Dr. Padula will almost always be confidential. I may occasionally find it helpful to consult with other mental health professionals about a case. I keep names confidential. I practice with other mental health professionals. If your case has to be discussed, I would obtain written consent from you first to proceed. You may decline that request as well. I may also need to share protected information on occasion with an office manager, your health care or health insurance providers, or my billing company, BOWER BILLING SERVICES. All of these professionals are bound by the same rules of confidentiality. I understand that a mental health professional, by law, must report actual or suspected child abuse or neglect or elder abuse or neglect to the appropriate authorities. In addition, Dr. Padula has the legal responsibility to protect anyone that may be threatened with violence, harmful or dangerous actions (including those to myself) and may break confidentiality of our communication if such a situation arises. I understand that the mental health professional will make reasonable efforts to resolve these situations before breaking confidentiality.

FINANCIAL RESPONSIBILITIES

I understand that I am financially responsible for the cost of the psychological services or any portion of the fees not reimbursed by my health insurance. Moreover, you need to be aware of your mental health benefits and not rely solely on CRR or BOWER BILLING SERVICES to be responsible for this. If my mental health care is provided under the terms and conditions of a managed health care program, which Dr. Padula is contracted, my financial responsibility may be limited to the terms of the contract. Failure to pay these bills may result in collection procedures (including court proceedings) being taken against me or a collection agency contracted by CRR to collect these bills. Furthermore, I will be responsible for any additional charges incurred through the use of collections agency or the filing of a court action, including attorney and filing costs. I further understand that professional services will be rendered to me by CRR. The initial assessment fee is $200 and the subsequent session fees are $185 per hour. For those without insurance, a fee will be assessed based on a range discussed at the time of the initial session. Fees may be billed for extra services, including treatment or case summaries and reports, court related proceedings and phone calls lasting more than 10 minutes (including coordination of care with other professionals and phone calls to clients directly). **INSURANCE COMPANIES DO NOT PAY FOR EXTRA TIME SPENT IN BETWEEN SESSIONS. AN HOURLY FEE WILL BE PRORATED BASED UPON THE SERVICES RENDERED.** I request the CRR submit my bill to the insurance company which I have listed on the Client Intake form, and I grant permission to Dr. Padula and BOWER BILLING SERVICES to release such confidential information as necessary to obtain payment from the insurance company, In the event that my insurance company fails to observe Ohio prompt payment standards of otherwise fails to adhere to appropriated business standards,

I grant permission to share information related to my insurance with the Ohio Department of
Insurance.

COPAYMENT POLICY

It will be necessary for all clients to pay their co-pay at the time of each visit. If CRR is required to send a statement for an outstanding balance due to overdue co-pay at the time of our scheduled visit, please reschedule more than 24 hours in advance to avoid a cancellation fee. If your adolescent children are coming for a session, please be sure they are prepared to pay the co-pay at the time of the visit.

ASSIGNMENT AND RELEASE

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE CENTER FOR REVOLUTIONARY RELATIONSHIPS. I AM FINANCIALLY RESPONSIBLE FOR NONCOVERED SERVICES AND DEDUCTIBLES. I ALSO AUTHORIZE CRR TO RELEASE ANY INFORMATION REQUESTED TO MY INSURANCE COMPANY, MANAGED CARE COMPANY, THIRD PARTY ADMINISTRATOR, BOWER BILLING SERVICES OR ANY OTHER PERSON OR ORGANIZATION NECESSARY IN THE SUBMISSION, PROCESSING AND APPROVAL OF CLAIMS, MY SIGNATURE BELOW INDICATES THAT I HAVE AGREED TO ALL THE ABOVE TERMS OF THIS CONSENT FOR TREATMENT/PROFESSIONAL SERVICES.

_____

CLIENT SIGNATURE OR PARENT/GUARDIAN **DATE**

SPOUSE/PARTNER SIGNATURE **DATE**

CLINICIAN SIGNATURE **DATE**

Notice of Privacy Practices- Brief Version

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

This practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full NPP, which you may request at any time.

We will use the information about your health, which we get from you or from others mainly to provide you with treatment (psychotherapy), to arrange payment for our services, and for some other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use your information. If you do not consent and sign this form, we cannot treat you.

If you or we desire to use or disclose (send, share, release, receive) your information for any other purposes we will discuss this with you and ask you to sign a Release of Information form to allow us to do that.

Of course we will keep your health information private, but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. As required by law: Federal, State or Local Law.
5. For Workers Compensation and similar benefit programs.

There are some other situations like these but do not happen very often. They are described in the longer version of the NPP.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place, which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care of the payment of your care, such as family members and friends. We do not

have to agree to your request. However, if we do agree, we will keep your agreement, except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records, but not Psychotherapy Notes. You can obtain a copy of your records, but we may charge you. Contact our Privacy Officer to arrange how to see your records.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kind of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please advise. The effective date of this notice is 7/02/25

PRIVACY PRACTICES ACKNOWLEDGEMENT

CENTER FOR REVOLUTIONARY RELATIONSHIP, LLC
3200 W. MARKET ST., ST. 101
FAIRLAWN, OHIO 44333

ACKNOWLEDGEMENT FORM

I received the Notice of Private Practices and I have been provided an opportunity to review it.

Name_____**Birthdate**_____

Signature_____**Date**_____

Credit Card on File Authorization
Center for Revolutionary Relationships LLC
3200 W Market St., Ste 101
Fairlawn, OH 44333

Please complete this form if you would like the Center for Revolutionary Relationships to keep your credit card on file for future payments. A 2.65% credit card processing fee will be added to each transaction.

Card Holder Name: _____

Client Name: _____

Card Type: Visa MasterCard Discover Am Express (HSA)

Card Number _____

Expiration Date: _____ Security Code: _____ Zip Code: _____

I, _____ authorize Center for Revolutionary Relationships to charge my credit card for all services and charges (i.e. late cancellation fee or NC/NS fee) received at Center for Revolutionary Relationships.

Repetitive withdrawal: Please charge the card listed above for the amount due to Center for Revolutionary Relationships. _____ (Initial)
***If there are any changes to my insurance coverage or credit card information, I will notify the office immediately.**

Email address for receipt
_____

Signature of Cardholder_____
_____
Date _____

TELETHERAPY INFORMED CONSENT AGREEMENT

Teletherapy is an alternative means of providing mental health therapy, which we may need to utilize on an emergency basis during the COVID-19 pandemic. Utilizing video chats/cell/landline phones in place of traditional in-person, in-office sessions. Your signature/email response to this form indicates your acceptance of the following:

- Teletherapy includes consultation, treatment, emails, telephone conversations and other medical information utilizing interactive audio/video, or data communications and takes the place of in-office therapy sessions. Dr. Padula will conduct my therapy via cellphone, landline, video chat or computer and will inform me of the platform to be utilized.

- The laws of the State of Ohio govern Teletherapy. The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless mutually agreed upon.

- I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency department for assistance.

- In the event our teletherapy is not in my best interest, my therapist will explain that to me and suggest some alternative options better suited to my therapeutic needs.

- I understand that there are risk and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that the transmission of my information could be disrupted or distorted by technical failures. Unauthorized persons could interrupt the transmission of my information, and/or unauthorized persons could access the electronic storage of my medical information. (Note: Dr. Padula will be utilizing phone or video calls only, with NO storage of information). I am responsible for information security on my computer and or cell phone or landline.

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

  Client signature: _____ Date: _____
  Printed name: _____
  Best Phone number to reach me: _____
  (**Note: If unable to sign in person, please email acceptance to revorelationships@gmail.com)**