DBT CENTER
OF LAWRENCE

CLIENT DEMOGRAPHICS

Legal Name:_____ Preferred Name: _____

DOB:____/____/____ Phone Number:_____ Email:_____

Residential Address: _____
Address City State Zip

Billing Address: _____
Name Address City State Zip

If under 18: Guardian's Name: _____ Phone Number: _____

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex

Sexual Orientation: ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Asexual ☐ Queer ☐ Pansexual ☐ Other

Personal Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Please Ask Me

Gender Identity: ☐ Male ☐ Female ☐ Trans Male ☐ Trans Female ☐ Non-Binary ☐ Questioning

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Separated ☐ Widower ☐ Other

Race: ☐ American Indian/Alaska Native ☐ White/Caucasian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ Asian ☐ Other

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

Primary Care Physician or Referring Provider: _____

Primary Insurance Company:_____ Policy ID #: _____
Group#:_____ Subscriber's Full Name:_____
Subscriber DOB: _____/_____/_____ Relationship to Client:_____
Subscriber Address:_____
Address City State Zip

Secondary Insurance Company:_____ Policy ID #: _____
Group#:_____ Subscriber's Full Name:_____
Subscriber DOB: _____/_____/_____ Relationship to Client:_____
Subscriber Address:_____
Address City State Zip

Client ID: _____ DOB: ___/___/_____ Client Name: _____

DBT CENTER
OF LAWRENCE

ACKNOWLEDGMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and been given an opportunity to read a copy of the Notice of Privacy Practices of the DBT Center of Lawrence and Kansas City, LLC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the DBT Center of Lawrence and Kansas City, LLC at 785-424-7770 or info@dbtlawrence.com.

_____

Client/Parent/Guardian/Personal Representative Signature Date

_____

Client/Parent/Guardian/Personal Representative Printed Name

Please Initial:

_____ I have been offered a copy of Notice of Privacy Practices

_____

Witness Signature Printed Name Date

Client ID: _____ **DOB:** ___/___/_____ **Client Name:** _____

DBT CENTER
OF LAWRENCE

Informed Consent

Please initial indicating your acknowledgement and agreement of the following statements:

_____ **Treatment Agreement** – I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Treatment Services Agreement of the DBT Center of Lawrence.

_____ **Informed Consent for Teletherapy Services** – I acknowledge that I have read and understand the risks and responsibilities of participating in teletherapy services provided by The DBT Center.

Authorization for Alternative Communications: Text Messaging and Email Informed Consent:

_____ I hereby acknowledge that I have read and understand the risks and responsibilities involved in communicating with the DBT Center personnel by text/email messaging. I acknowledge these risks and accept personal responsibility for the risks in using this technology. I understand that I cannot hold the DBT Center personnel liable for complications that result from my choice to communicate in this manner.

_____ I consent to allow DBT Center personnel to correspond by text message/email with me. I am responsible for providing the DBT Center with my current cell phone number and email address.

Text Number: _____ - _____ - _____ Email Address: _____

Payment Agreement:

_____ I hereby acknowledge and understand that I am financially responsible for any charges not paid by insurance. (e.g., copays, deductible, coinsurance, out of pocket costs, loss of coverage, etc.).

_____ I authorize the DBT Center of Lawrence and Kansas City, LLC to submit insurance claims on my behalf and release any information required to process any and all claims for reimbursement.

I understand that my signature below indicates that I have read the DBT Center of Lawrence and Kansas City, LLC Treatment Services Agreement in its entirety and agree to its terms. Should I have any questions regarding this agreement, I can contact the DBT Center of Lawrence at 785-424-7770 or info@dbtlawrence.com.

_____
Client/Parent/Guardian/Personal Representative Signature Date

_____
Client/Parent/Guardian/Personal Representative Printed Name

_____
Witness Signature Printed Name Date

Client ID: _____ DOB: ___/___/_____ Client Name: _____

Updated October 12, 2022

DBT CENTER
OF LAWRENCE

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until terminated.

Credit Card Information:

Card Type: ▢ VISA ▢ Discover ▢ MasterCard ▢ Other:_____

Cardholder Name (as shown on card):_____

Cardholder Address:_____

Card Number:_____

Expiration Date (mm/yy):_____ CVV:_____

Transaction Frequency and Amount:

Account balances will be processed at the beginning of each week unless otherwise indicated.

Other Frequency/Amount (please specify): _____

Please initial the following statements:

_____ I certify that I am an authorized user of this credit card.

_____ I understand that if a chargeback fee is incurred, I am responsible for that fee.

_____ I understand that my card information will be saved on file for future transactions on my account.

_____ I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with DBT Center of Lawrence and Kansas City, LLC and those attempts have failed.

By signing this agreement I authorize DBT Center of Lawrence and Kansas City, LLC to keep my signature and my credit card information securely on file in my account and to charge my credit card above for agreed upon purchases. I understand that if I have any questions regarding this authorization form, I can contact the DBT Center of Lawrence at 785-424-7770 or alyssa@dbtlawrence.com.

_____
Client/Parent/Guardian/Personal Representative Signature Date

_____
Client/Parent/Guardian/Personal Representative Printed Name

_____
Witness Signature Printed Name Date

Client ID: _____ DOB: ___/___/_____ Client Name: _____

Updated October 10, 2023

DBT CENTER
OF LAWRENCE

EMERGENCY CONTACT INFORMATION FORM

Client Name: _____ DOB: ____ / ____ / _____

The information on this form is to be used strictly in an emergency or crisis situation. Please list family members or friends that we may contact in case of an emergency.

Primary Contact Person:

Name: _____

Address:_____ City:_____

State:_____ Zip: _____ Relationship to this Person: _____

Cell #: _____ Work Phone: _____

Secondary Contact Person:

Name: _____

Address:_____ City:_____

State:_____ Zip: _____ Relationship to this Person: _____

Cell #: _____ Work Phone: _____

_____

Client/Parent/Guardian/Personal Representative Signature Date

_____

Client/Parent/Guardian/Personal Representative Printed Name

_____

Signature of Witness Print Name Date

Client ID: _____ DOB: ___/___/_____ Client Name: _____

DBT CENTER
OF LAWRENCE

CONSENT FOR FACE-TO-FACE MEETINGS (COVID-19 RISKS)

When we hold meeting in the office, we follow safety guidelines from the Centers for Disease Control to minimize the spread of COVID-19 and other respiratory infections.

1. Only patients who have been fully vaccinated against COVID-19 will be allowed to come to the office for individual and group treatment services. Patients must send an image of their official vaccination card to info@dbtlawrence.com. Vaccination is not needed for remote video (telehealth) individual or group treatment services.
2. Your therapist may ask you to wear a face mask during your individual therapy sessions.

Procedures for Therapy Groups

1. Before entering the office building for a skills group, we will ask patients about recent symptoms of COVID-19 exposure.
2. Patients will not be allowed to walk into our skills groups if:
    a. They are not wearing a face mask or if it is not fully covering their nose and mouth)
    b. They report COVID-19 symptoms.
    c. After having been exposed to someone with COVID-19 symptoms they have not yet had a negative COVID-19 test.
3. Whenever patients have a high temperature, a cough, or other COVID-19 symptoms, they will only be allowed to join the group remotely through video (telehealth) and will not be allowed to enter our office.
4. This means you should be prepared to quickly join group on your phone or device in case you unexpectedly do not pass our screening on a particular day. Your group therapist will send you an email which includes the Zoom link for both video and audio options. We suggest you save the URL/link as a bookmark/shortcut on your device and save it on your phone and test them out with a therapist in advance.
5. Patients will be asked to leave our skills group if they do not continuously wear a face mask (or if it is not continuously fully covering their nose and mouth).
6. We ask that group clients bring their own skills binder, pen, and face mask.
7. When you arrive early for a group, please wait in your car or away from the building.

We give every client the option of remote video meetings, also known as telehealth, for both individual and group therapy services. If you are not comfortable with our safety procedures or the possible health risks of in-person treatment services, you can enroll in a telehealth group (no in person meetings).

By signing below, you are choosing to participate in therapy treatment services at our office with full awareness that you could be exposed to COVID-19 during your treatment services (e.g., individual and group therapy), despite our precautions. The DBT Center of Lawrence and Kansas City, LLC makes no representation, express or implied, that you will not be exposed to COVID-19, or any variant, by your participation in therapy treatment.

By signing below, you are agreeing that the DBT Center of Lawrence and Kansas City, LLC is not liable should you be exposed and/or contract COVID-19 and any of its variants. You also agree by signing below to release and waive any and all claims against DBT Center of Lawrence and Kansas City, LLC, its professionals, representatives, agents, and or others acting on its behalf, for injury or illness from exposure to the COVID-19 arising out of your therapy treatment at our office.

_____

Client/Parent/Guardian/Personal Representative Signature Date

_____

Client/Parent/Guardian/Personal Representative Printed Name

_____

Witness Signature Printed Name Date

Client ID: _____ DOB: ___/___/_____ Client Name: _____

Updated October 12, 2022

DBT CENTER OF LAWRENCE
AUTHORIZATION FOR RELEASE AND OBTAINMENT OF INFORMATION

A release of your Protected Health Information (PHI) is required in order for the DBT Center of Lawrence to collaborate with other professionals or talk with anyone about you or your care to coordinate care with the individual/institution listed below during the course of your treatment. We ask you to complete this form for any individual (spouse, parent, guardian, other providers, etc.) whom you consent to have your information released, either verbally or in writing. This includes written records, verbal communication, or information shared via text or email. You can also find this form on our website: www.dbtlawrence.com.

Parents and Guardians. In order for us to speak with parents and guardians on behalf of their child (age 18 or older) about their PHI, *we are required to have the client's written consent*.

PERSON COMPLETING THIS FORM (YOURSELF OR ON BEHALF OF DEPENDENT FOR WHOM YOU ARE GUARDIAN)

_____
First Name Last Name Date of Birth

_____
Address City State Zip Code

I authorize the release and/or obtainment of the following (mark any that apply):

RELEASE	OBTAIN		RELEASE	OBTAIN		RELEASE	OBTAIN	
☐	☐	Billing/Financial		☐	Lab/EKG	☐	☐	Psychological tests, assessments, evaluations
	☐	Crisis screening report	☐	☐	Legal Information	☐	☐	Safety Plan
	☐	Custody Evaluation		☐	Medical discharge summary	☐	☐	Scheduling
☐	☐	Diagnosis/Prognosis		☐	Medication record	☐	☐	Substance abuse information
☐	☐	Educational records		☐	Physician's orders	☐	☐	Treatment Plan
	☐	HIV/AIDS status	☐	☐	Presence in treatment	☐	☐	Other: _____
☐	☐	Intake Evaluation	☐	☐	Progress/Therapy Notes			

THE DBT CENTER HAS PERMISSION TO RELEASE/OBTAIN INFORMATION FROM THE FOLLOWING:

_____
Name or "Staff" Relationship to Client/Organization Name Address

_____
City State Zip Phone Fax Email*

*By providing an email address for this individual, you agree to release the DBT Center of Lawrence to use this method of communication with this individual by email and understand that these communications may not be completely secure while using the Internet. Do not provide an email address if you do not want this form of communication used.

AUTHORIZATION

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulation. This authorization is valid until 90 days after my chart is closed at the DBT Center of Lawrence or until such time as I provide written revocation and it has been received by the DBT Center of Lawrence, or by:____ / ____ / _____.

In addition, I understand that revoking this authorization at any time will not affect any action taken in reliance of this authorization before the written revocation was received. If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.

_____
Client/Parent/Guardian/Personal Representative Signature Printed Name Date

_____
Witness Signature Printed Name Date

Client ID: _____ DOB: ___/___/_____ Legal Name: _____