

Danny Wright, LCSW  
*Licensed Clinical Social Worker*  
3633 Wheeler Road, Suite 100  
Augusta, GA 30909  
Phone: (706)364-0252 Fax: (706)364-0269

**\*\*\*IMPORTANT INSURANCE INFORMATION\*\*\***

**We do not guarantee insurance benefits or insurance payments. We also do not guarantee that a provider is in network for any patient's plan. We request all patients to contact their individual insurance company to verify benefits and provider network status before their appointment.**

**Please sign acknowledgement of this information.**

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**Signature**

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**Date**

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Today's Date: \_\_\_\_\_

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ Last: \_\_\_\_\_ MI. \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_ Wk Phone: ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Social Security No. : \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_

Email: \_\_\_\_\_

Family Physician: (Name, Address, & Phone): \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security No. \_\_\_\_\_ Work Phone: \_\_\_\_\_

**If Patient is a Minor:**

Parent/Legal Guardian Name: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

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## EMAIL AND TEXT MESSAGING CONSENT FORM

I, \_\_\_\_\_ authorize \_\_\_\_\_  
(Patient printed name) (Therapist name)

to send automated appointment reminder email and/or text messages to me. I understand my Therapist is not responsible for any breach of privacy, confidentiality, or security of the emails/texts once they are received on my electronic devices. I understand the reminder system is automated and does accept reply emails/texts and is used for the sole purpose of appointment reminders. I agree to call the Clinicians Office at 706-364-0252 within regular business hours to cancel/reschedule appointments. I understand I may be charged a late cancellation/no show fee if I do not honor the 24-hour cancellation notice policy. In the case of an emergency, I agree to notify the office as soon as possible.

### Contact by text messages:

- I **DO** wish to have this contact at the following phone number:

\_\_\_\_\_

- I **DO NOT** wish to have this contact.

### Contact by email:

- I **DO** wish to have this contact at the following email address:

\_\_\_\_\_

- I **DO NOT** wish to have this contact.

\_\_\_\_\_  
(Patient/Custodial Parent/Legal Guardian)

\_\_\_\_\_  
(Date of Signature)

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**Insurance Information:**

**Primary Insurance Company:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize payment of private therapist fee benefits of insurance specified in attached form, and which may be otherwise payable to me, to be directly paid to Danny Wright, LCSW but not exceeding the balance due of such therapist's regular charges for such service. I permit a copy of this authorization to be used in place of the original document.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(Patient/Custodial Parent/Legal Guardian)

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**\*\*\*Please give the receptionist your insurance card at the time of check-in. If you have two insurance companies, please inform us at your first visit.**

**Consent for Disclosure of Information to Third Party Payers (Entities that pay your claims):**

The undersigned authorizes Danny Wright, LCSW to release all patient information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being evaluated and treated, to the insurance company, the third party payer, or its representatives.

The undersigned acknowledges that such disclosures shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the insurance company or third party payer.

The undersigned understands that the information obtained by use of this "Authorization" may be used by the above mentioned insurance company or third party payer to determine eligibility for benefits under an existing policy, and further understands that information obtained by such insurance company or third party payer shall not be released to any other person unless the undersigned so authorizes.

The undersigned acknowledges that he/she may request to receive a copy of this Authorization for disclosure of information to third party payers, and that he/she may revoke this Authorization at any time, except to the extent that action has been taken in reliance thereon.

The undersigned further acknowledges that this Authorization shall be valid during the pendency of these claims.

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Signature of Patient/Custodial Parent/Legal Guardian

---

Date

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## **PATIENT RIGHTS/RESPONSIBILITIES**

### **PATIENT RIGHTS**

Each patient, adult, child, adolescent, parent, or guardian has inherent and moral rights. It is my policy to ensure the rights of all patients by the following:

Courtesy: The patient deserves fair, considerate, humane, and respectful care. The patient will not be denied needed diagnostic and therapeutic services that are within my capabilities. Each patient will have equitable and impartial care throughout this facility.

Confidentiality: Certain information obtained concerning you the patient, are, of course, confidential and privileged. When requested to furnish this classified information I will state that the information I have received is confidential and cannot be revealed except with authorization from the patient or someone empowered to speak for the patient. Medical information shall be available for use within my facility for direct patient care by all authorized personnel involved with the care of the patient.

The physical Medical Record is the property of my office and may not be removed from this jurisdiction and safekeeping except in accordance with a court order, subpoena, or other statute. The information contained in the Medical Record belongs to the patient. The patient is entitled to the right of protection of the confidentiality of this information but may authorize release of such confidential information through written consent. Upon employment, personnel involved with the care of the patient will sign a statement assuring the confidentiality of patient information.

Knowledge: The patient has the right to know the identity of the staff members involved in their care.

The patient has the right to view their clinical records or reports. Office personnel will offer no explanation of such records or reports, but will encourage the patient or guardian to discuss them with me.

The patient will have access to their bill upon request by a manager or supervisor. The patient may request complete information and explanation of the charges for diagnostic and therapeutic services.

Complaints: The patient and their family have the right to make complaints regarding treatment. Presenting a complaint will not in itself affect the access to services now or in the future. The manager will review each complaint. Appropriate action will be taken and communication of that action provided to those involved.

### **PATIENT RESPONSIBILITIES**

Information: The patient must provide true, accurate, and complete information.

Instructions: The patient must follow instructions for treatment. The patient should understand the consequences of not doing so, and if unable to comply, they must inform the staff or myself so that efforts can be made to help.

Refusal of Treatment: The patient and family are responsible for outcomes if they do not follow the medical plan of treatment and discontinue treatment against medical advice.

Respect and Consideration: Patients and their family must show consideration to other patients and staff, help control noise, distractions, and the “no smoking” policy of this building. Patients and family must respect the property of others and my office.

Obligations: The patient must keep appointments and fulfill obligations for their diagnostic and therapeutic services.

Behavior: The patient must abide by the rules and regulations of my office.

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Signature of Patient/Custodial Parent/Legal Guardian

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Date

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Not all services are a covered benefit in all insurance plans. **Patients are expected to pay for any part of charges not covered by insurance.** Unless prohibited by contract, patients will be billed for any unforeseen account balances after insurance has paid. A charge of \$25.00 will be assessed on all returned personal checks. Should your account be turned over to a collection agency, you will be responsible for any collection fees, attorney fees, and court costs. The billing staff will discuss any questions with you at any time. If temporary financial problems affecting timely payment should arise, please contact us promptly for assistance in management of you account.

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Signature of Patient/Custodial Parent/Legal Guardian

---

Date

I agree there is to be no use of any type of visual or auditory recording devises at any time without the knowledge and consent of all adult parties present.

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Signature of Patient/Custodial Parent/Legal Guardian

---

Date

### CANCELLATION/NO SHOW POLICY

You are expected to remember your appointments whether or not our office staff is able to contact you with a reminder call. Again, please cancel any appointment you cannot keep at least 24 hours prior to the scheduled time. If an emergency prohibits you from the 24 hour notice, this should be the exception rather than the rule. You are asked to call the office during the available business hours rather than routinely using the after-hours protocol.

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Signature of Patient/Custodial Parent/Legal Guardian

---

Date

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## Client Information and Informed Consent for Telemental Health Treatment

Telemental health services involve the use of electronic communications (telephone, video conference, etc.) to enable therapists to provide services to individuals remotely. Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are usually minor depending on the needs of the client and the care with which the technology (cell phone, tablet, computer, etc.) is utilized.

### Timely notification:

My intention is that telemental health be offered at my practice during the extent of the Covid-19 public health crisis. I cannot guarantee that services via telehealth will continue after this health emergency has abated. Please note the Department of Health and Human Services (HHS) has amended some telehealth HIPAA requirements during the COVID-19 national emergency to allow use of some technologies not previously compliant with HIPAA rules. This change is meant to make it easier for providers and patients to have access to needed services. Some of the telehealth communications I may use with you are examples of these newly amended protocols. For more details, please visit <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>.

### Additional Points for Client Understanding:

- I understand that this form is signed in addition to the paperwork you completed as a new patient and does not change any of the *Client Consent for Counseling* documents I agreed to previously. (A copy of the new patient paperwork is available on the office website for you to review, if needed.)
- I understand that my Initial Consultation will be done using telemental health.
- I understand that telemental health services are completely voluntary and that I can choose not to do it at any time.
- I understand that none of the telemental health sessions will be recorded or photographed by my therapist without my written permission, and I understand that I may not record or photograph any of my telemental health sessions without the written permission of my therapist.
- I understand that the laws that protect the privacy and confidentiality of client information also apply to telemental health. No information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
- I understand that because this is a technologically-based method it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
- I understand telemental health is performed over as secure a communication system as possible at this time and that it is difficult for anyone else to access these systems. I also understand there is still a possibility of a breach; I accept the rare risk that this could affect confidentiality.
- I understand that there are risks from telemental health that may include but are not limited to the possibility despite all reasonable efforts by my provider: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner.
- I understand that telemental health sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my therapist.
- I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed.
- I understand I am responsible for creating a safe, confidential space during sessions. I will engage in sessions in a private location where I cannot be heard or seen by others.
- I understand I am responsible for logging out or hanging up once sessions are complete.
- I understand you may contact me from a blocked number to avoid others knowing we have connected.
- I understand that if there is an emergency during a telemental health session, then my therapist will call emergency services and my emergency contact. I understand that if I do not follow safety/emergency protocols, my therapist has the right to discontinue use of teletherapy to protect my safety and well-being.
- I understand that if the video conferencing or telephone connection drops while I am in a session, I will provide a phone number (see below) for follow up contact if a plan for technical failures has not already been arranged with my therapist.
- I understand that I am required to provide an emergency contact (see below) in case of an emergency.



- I understand that telemental health services may not be appropriate for everyone seeking therapy. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services), she will make every effort under the circumstances of the COVID-19 crisis to refer me to a practitioner who can provide such services in my area.
- I understand I may be requested to install applications specific to treatment onto my phone, tablet or computer device. Some applications specifically interact via phone /tablet, device, etc. and have the capability to report activity, GPS location, etc.
- I understand I have the right to withdraw this consent at any time. However, if I do so, this may require my therapist to provide referrals to other treatment providers if face-to-face services are not an option based on geography and/or circumstance.
- I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the *Client Consent for Counseling* agreement. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.
- I understand that email is not an appropriate means of communicating with my therapist in the case of emergency. I understand the email address provided below is to be used for providing this form only and is not an email that is monitored by my therapist. Any email address used by my therapist to engage in video conferencing is also not meant to be used in the case of an emergency or for counseling related content to be shared. I understand that email is not a secure communication medium for sensitive/personal information. I agree to call the office for scheduling, insurance questions, or supplying other information.

**Emergency Contact Name:** \_\_\_\_\_ **Emergency Contact Number:** \_\_\_\_\_

**CANCELLATION/NO SHOW POLICY**

If you need to cancel an appointment, please follow the same procedure you already agreed to in your original *Client Consent for Counseling* documents. **As a reminder, cancellations should be made within 24 hours of your scheduled session time, unless you have a same day emergency arise. We understand this may be a more common occurrence in current times but please be sensitive to the needs of other patients needing appointments and the impact cancellations have on my practice now more than ever before.** Please call and inform our office of any same day emergencies. **If cancellation is not made within 24 hours, I reserve the right to charge a \$65 fee in the same way a fee is charged for missing or late cancelling in-person sessions.**

**PAYMENT FOR SERVICES**

As with your face to face sessions, we will submit a claim to any insurance provider you gave us written consent to bill in your *Consent for Disclosure of Information to Third Party Payors* in the new patient paperwork completed at your first visit. Not all mental health services are a covered benefit in all insurance plans. However, it is our understanding at this time that most insurers are covering telemental health services during this emergency period. If you feel unsure, please contact your insurance company. **Patients are expected to pay for any part of charges not covered by insurance per usual procedure (i.e., copay, deductibles, etc.).** Billing processes remain the same for telemental health services as with in-office visits, as outlined in the *Client Consent for Counseling* document. Self-pay arrangements already in place will remain the same for teletherapy sessions. **It is preferable that payments are made by phone. The front office will call you to obtain your credit card information after your session concludes.** It is also possible I may need to help relieve the burden on the front office by collecting your credit card information during our sessions and processing the payment later. If an alternative form of payment is needed, please discuss this with me. Please be patient with us as we do our very best to continue offering you counseling services in an ever-changing situation.

**CONSENT**

I consent to engaging in telemental health as part of my treatment with Danny Wright, LCSW. I understand that “telemental health” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications. I understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health in my care.

Name of Patient (Print) \_\_\_\_\_ Email (Print) \_\_\_\_\_ Cell Phone \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

Name of Legal Guardian [if patient under 18] (Print) \_\_\_\_\_ Signature of Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*We want to make returning this form to our office as easy as possible amid the COVID-19 health crisis. If you are attending a session in person, bring the form with you or ask the front office for a copy. You may also download and sign the form and email it back to the office at [renee.rbgs@gmail.com](mailto:renee.rbgs@gmail.com). If you have an easy way to scan your signed document and email it back to us, that's great. If not, you may take a photo with your smartphone and email it. If you have access to a fax, our fax number is 706-364-0269. You may also download, sign, and mail it to our office at the address at the top of this document. Need help? Give us a call at 706-364-0252. Thank you!\*\***

## **INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS**

This document contains important information about in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

### **Decision to Meet Face-to-Face**

There may be a need to meet in person for some or all of our sessions. We will need to agree to meet in person. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

### **Risks of Opting for In-Person Services**

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

### **Your Responsibility to Minimize Your Exposure**

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free.
- You will wear a mask/face covering in our suite until you reach my office. You and I will decide together if masks will be worn during your therapy session.
- The waiting room should be limited to patients being seen for therapy sessions. Minor patients or patients needing physical assistance may bring 1 person with them into the waiting room.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately inform me/office staff.
- If a resident of your home tests positive for the infection, you will immediately let me/office staff know and we will then [begin] resume treatment via telehealth.

- I understand that my therapist cannot be held responsible for any exposure risks outside of the therapy office in other parts of the building or the parking lot. \_\_\_\_\_
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with therapists or staff. \_\_\_\_\_

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

**If You or I Are Sick**

You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

**Your Confidentiality in the Case of Infection**

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

**Informed Consent**

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

\_\_\_\_\_

Patient

\_\_\_\_\_

Date

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**INFORMED CONSENT AND TREATMENT AUTHORIZATION:**

By signing this Patient Informed Consent and Authorization as the Patient or Guardian of said Patient, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I am voluntarily agreeing to receive mental health assessment, treatment and services, from Danny Wright, LCSW , for me (or my child if said child is the patient).

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my/their health insurance. Deductibles and co-payments will be made at the time services are rendered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**IN CASE OF EMERGENCY CONTACT:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NO: \_\_\_\_\_

Whom may we thank for referring you to us?  
\_\_\_\_\_

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**\*\*WOULD YOU LIKE INFORMATION RELEASED TO YOUR PRIMARY CARE PHYSICIAN?**

**YES \_\_\_\_\_ (COMPLETE ALL INFORMATION BELOW – SIGN & DATE)**

**NO \_\_\_\_\_ (\*\*PLEASE SIGN & DATE AT THE BOTTOM)**

Client: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I, \_\_\_\_\_, authorize Danny Wright, LCSW and my primary care physician,

Dr. \_\_\_\_\_

Phone# \_\_\_\_\_ fax# \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

to exchange information regarding my mental health and/or substance abuse treatment and medical health care for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care and/or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for 12 months from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my primary care physician.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Custodial Parent/Legal Guardian)