REGISTRATION

Name ______________________________

Date of Birth　　　Today's Date ______________________________

SSN: ____-____-____ Sex: ___ Race: ___ Marital Status: ___ Maiden Name: __________

Street: ______________________________

City: ______________________________ State: _____ Zip Code: __________

Primary Phone: first number used to contact you　　Secondary Phone:

_______-_______-_______　　_______-_______-_______

❑ Home ❑ Mobile ❑ Work　　❑ Home ❑ Mobile ❑ Work

Do not leave ❑ messages, ❑ text message.　　Do not leave ❑ messages, ❑ text message.

Employment

Employer: ______________________________ Occupation: __________

Street: ______________________________

City: ______________________________ State: _____ Zip Code: __________

Responsible Party

Name (Last, First MI): ______________________________

Street: ______________________________

City: ______________________________ State: _____ Zip Code: __________

Phone: _____-_____-_____ Relationship: ______________________________

Emergency Contact Information

Emergency Contact: ______________________________ Phone: _____-_____-_____

Relationship: ______________________________ ❑ Home ❑ Mobile ❑ Work

Referral Source: Who may we thank for referring you?

Name: ______________________________

Street: ______________________________

City: ______________________________ State: _____ Zip Code: __________

❑ Doctor ❑ Relative/Friend ❑ Ministry/Clergy ❑ Other: ______________________________

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

Notice of Privacy Practices: You may be aware of the Health Insurance Portability and Accountability Act (HIPAA) which regulates the use/privacy of your health information by hospitals, doctors, and other healthcare providers.

The regulations incorporated into this notice explain how The Center for Counseling, Health, and Wellness, PLLC (herein after, "The Center") may use and disclose your Protected Health Information (PHI) for purposes that are permitted or required by law. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future health or condition and related care services.

We are required to provide this notice to you and to comply with it in order to keep your health information private. We have a right to change these privacy practices as long as those changes are permitted by law. A current and revised copy of this notice is available upon request. You may call or e-mail the office and a copy will be sent to you in the mail or by e-mail, or you may ask for one at the time of your next appointment.

Uses and Disclosures of your PHI based upon your written Authorization: Use and disclosure of your PHI will only be made with your written authorization unless otherwise permitted by law. Anyone who receives such information may not re-disclose it without your consent or as otherwise authorized by law. An authorization is written permission from you that permits specific use or disclosure of your PHI. You may revoke your authorization at any time in writing unless the Center has taken action in reliance upon the use or disclosure in the authorization.

Other Permitted and Required Uses and Disclosures:

-To any person required by federal, state, or local laws to have lawful access to your PHI (i.e., court orders);
-To persons/departments within the operation of the Center (i.e., billing);
-To outside service organizations that provide professional services to the Center (i.e., data processing, collections, and laboratories);
-To third party payors for purposes of health insurance reimbursement;
-To medical personnel in medical emergency requiring immediate medical intervention; and/or
-Access to your records may also be permitted under certain circumstances for: research, as well as audits or evaluations conducted by regulatory agencies, private third payers, funders and private peer review organizations. Information disclosed during and audit or evaluation will not be re-disclosed except pursuant to a court order.

By statute of the Commonwealth of Kentucky, the Center may disclose your PHI without your consent or authorization under certain circumstances including:

-Your prior written authorization to release the information;
-Suspected or known abuse or neglect of children or adults, including domestic violence;
-Pursuant to the order of a court of competent jurisdiction;
-A serious threat to any person's health or safety, including your own;
-Worker's Compensation; and/or
-To the parent of any minor or the legal guardian of any individual declared to be incompetent.

Additional uses and disclosures:

We may use your demographic information to send you a newsletter about the Center or to contact you regarding fundraising activities. We will not sell your demographic information to outside companies. If you do not want to receive these communications, please contact your Counselor.

As a client of the Center, you have important rights with respect to your PHI:

With limited exceptions, you have a right, upon written request, to inspect and receive copies of your health information that is maintained by us for our use. We will charge $1 per page for photocopies.

You have a right, upon written request, to receive confidential communications from us by alternate means or at an alternate location. For example, you may not want a family member to know that you are receiving services here. Your written request must specify the alternative means and/or location.

You have a right to request that we amend your PHI. In certain cases, we may deny your request for an amendment in which case we will notify you. If we approve your written amendment, we will modify our records accordingly. If we deny the amendment you propose, we will notify you and you can place a written statement in our records disagreeing with our denial.

You have a right to make a written request that we provide you with a list of those occasions where we disclose your PHI.

You have a right to obtain a paper copy of this notice from us at no charge even if you have agreed to accept this notice electronically.

You have a right to make a written request for other restrictions on the ways we use or disclose your PHI. We will accommodate reasonable requests, but are not required to agree to a restriction that you request in which case we will notify you. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Questions and Complaints: If you have any questions about the material in this notice, please ask for assistance. If you are concerned that we have violated our privacy practices, or if you disagree with a decision we made about access to your records, you may make a complaint in writing. Contact your Counselor for further information. You may also submit a written complaint to the Secretary of the US Department of Health and Human Services. We will provide you with that address upon written request.

____ _____-_____-_____

Client Signature and Printed Name Date

ASSESSMENT SERVICES AGREEMENT

This document (the Agreement) contains important information about services rendered at and the business policies of The Center for Counseling, Health, and Wellness, PLLC (herein after, "the Center"). I understand it is to my advantage to familiarize myself with it in order to gain the most out of my treatment at the Center.

Attention
If you have any questions regarding the completion of the *Assessment Services Agreement*, please be sure to ask the Center **first**. Also, if the person seeking services at the Center is aged 18 and above, they are required to complete this *Counseling Services Agreement*; parents and partners cannot complete this form. With my initials, I acknowledge I am NOT completing this form for another person.
__________*Initials*

The Assessment Process
Through the use of a variety of standard tests, we will attempt to answer the questions that have brought you for this assessment. These questions generally concern mental health diagnoses, substance use diagnoses, personality functioning, or coping styles. Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations.

The assessment process generally involves an informational interview followed by the administration of one or more tests. Although it is sometimes possible to complete testing in one sitting, it typically takes about three to four hours for a full battery (interview and tests), and so is common for us to complete the assessment process in more than one session. Once testing is completed, the data will be analyzed and a report will be written. Your Professional Counselor will contact you to schedule a Feedback Session, when you will then have the opportunity to meet with your Professional Counselor to discuss the results and receive a copy of the report (if a report is required or necessary). Our general turnaround time for completed reports is about two weeks.

Type of Assessments
<u>Psycho-Educational Assessment</u>. The purpose of this evaluation is to provide an in-depth study of the cognitive processes and personality functioning of an individual. This evaluation can be used to diagnose learning, behavioral, ADHD, and psychiatric disorders.

<u>Diagnostic Assessment</u>. The purpose of this is to diagnose behavioral and/or emotional disorders.

It is important to understand that the Center for Counseling, Health and Wellness (hereinafter, "the Center") does not perform custody evaluations for children, which is a highly specialized field. In addition, the Center does not perform forensic evaluations (to examine and evaluate a

person in anticipation of prosecution or litigation). Should you be seeking one of these kinds of evaluation, please consult with expert specialists in those areas.

Types of Measures

Cognitive Testing—to assess strengths and weaknesses in intellectual abilities, specifically Crystalized Intelligence, Visual/Spatial Processing, Fluid Reasoning, Processing Speed, Short-term Memory, Long-term Retrieval, and Auditory Processing.
Achievement Testing—may be in the areas of Reading (decoding and comprehension), written language, math reasoning and calculations, academic fluency, and oral language.
Attention and Executive Function Testing—testing includes individual processing tests of attention and executive functioning, as well as questionnaires. Questionnaires are to be completed by both the examinee and an individual who knows them well (parent, guardian, teacher, friend, or partner).
Diagnostic Interview and Developmental History—to obtain information of the examinee outside of the testing situation, and to have a sufficiently comprehensive history in order make a more reliable diagnosis.
Behavior Rating Scales and/or onsite observation at school in order to get a sample of behavior that occurs outside the office setting.
Clinical Tests (standardized and projective tests)—to obtain information on the individual pertaining to psychiatric diagnoses, interpersonal relationships, self-concept, etc.
Interviews with teachers, other family members, physicians, or other relevant individuals (Note: interviews will only be performed with written consent).

Professional Counselor

Dr. David C. Maynard is a mental health professional holding a license in the field of Professional Counseling. He has been trained and supervised in administration of the assessment (interviewing and testing) and regularly consults with colleagues competent in assessment.

Fee and Payment Policy

The standard fee for a testing battery is $31.25 per 15 minutes for all activities involved in the completion of your assessment, plus the cost to the Center for the assessment instruments themselves (the instrument cost will be disclosed to you before administration of it). The fee may be adjusted at times depending upon the purpose of the evaluation and the tests used. Any adjustment to the standard fee will be noted in the space below. The Center does not bill insurance companies. We ask that you pay your fee in full at your first appointment with your clinician, unless specific arrangements have been made.

I understand that if I become involved in legal proceedings that require the participation of the Center or my Counselor, I will be charged for services rendered, including preparation and costs of transportation, even if another party requires it. Due to the complexity of legal involvement, the Center charges $175.00 per hour, plus the Center and/or Counselor's attorney fees incurred, and requires a $2,500.00 retainer.

I agree to place an active credit card on file, and that if my invoice has not been paid in 30 days or arrangements for payment have not been made, the Center may charge my credit card or

use legal means to secure the payment. I understand that once my credit card number is in the system no one will be able to see the number. Using legal means to secure payment may involve hiring a collection agency or going through small claims court, which will require disclosure of otherwise confidential information. I understand and agree to pay any costs associated with such legal action, which will be included in the claim.
__________*Initials*

We accept MasterCard and Visa credit cards. Questions concerning the fee or the payment policy should be discussed with your Professional Counselor before the assessment process begins.

I request the the Center, on my behalf and as a courtesy, periodically charge my credit card for the balance I owe. I understand this is payment arrangement is valid, unless I cancel the authorization in writing.

____
Signature

Requesting Agency
The assessment report is generally released to the clinician or agency (e.g., professional license board) who requested the testing or to the individual client when the testing is requested by self-referral. The overall time required depends on the nature of the assessment and the consultation question that is being addressed. There can be no guarantees about the outcome of the assessment or what the requesting clinician or agency will do with the results, and how that may or may not impact your relationship with the requesting clinician or agency.

Informed Consent for Assessment and Testing
I understand that the information obtained in this assessment is confidential and will not be released to any person or organization without my written permission (the Authorization for Release of Information). The only exceptions to this policy are rare situations in which you are required by law to release information with or without my permission. These are: (1) if there is evidence of physical and/or sexual abuse of children or the elderly; (2) if you judge that I am in danger of harming myself or another individual; and (3) if my records are subpoenaed by the court. In the rare instance of any of these situations, you would limit disclosure of confidential information to the minimum necessary to insure safety.

I understand that, if the Center deems that additional or alternative testing be necessary, the Professional Counselor will describe in written form the reasons for this testing and will advise me of any additional costs. I understand that I have the right to discontinue the assessment process at any time. However, I understand that the Center may be unable to provide feedback on the test results if the testing is terminated, and that I will still be responsible for payment of any testing, scoring, and assessment time up until that point.

I understand that undergoing an assessment (interview, testing, and/or collateral information) may involve discussing unpleasant aspects of my life and may lead to unanticipated results and/or conclusions you find to be discomforting or embarrassing. The Center attempts to minimize these risks by thoroughly reviewing the nature and purpose of the assessment with

me and explaining the results in language I can understand. Information from my assessment is contained in a confidential medical record.

By my signature below, I acknowledge that I freely consent to an assessment (interview, testing, and/or collateral information) by the Center for Counseling, Health and Wellness, that I, having read this consent form, have been informed of the policies regarding assessments at the Center, and that I agree to all of the payment arrangements outlined in this form. I fully understand my rights and obligations as a client at the Center.

Confidentiality from the Center and/or Counselor
I understand that conversations with the Center and Counselor will almost always be confidential. I further understand that the Center and Counselor, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. In addition, the Center and Counselor has a legal responsibility to protect anyone that is threatened with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the Center and/or Counselor will make reasonable efforts to resolve these situations before breaking confidentiality. In the event I have any questions regarding confidentiality, I will consult this Agreement and the Notice of Privacy Practices for Protected Health Information provided to me by the Center, and then my Counselor.

I understand the law protects the privacy of all communications between a client and Counselor. In most situations, information can only be released about my treatment to others if I sign a written authorization form, which meets certain legal requirements imposed by HIPAA (Federal law). In addition to the legal responsibility stated here, the Center and/or Counselor are permitted and/or required to disclose information without either my consent or authorization. Such events include, but are not limited to, a court order or subpoena, or a complaint or lawsuit filed against the Center and/or Counselor for defense purposes. It is the policy of the Center to limit any disclosures.
__________*Initials*

Contact by the Center
I understand it is the policy of the Center to limit the information left on voicemails or with a person, only the name of the staff calling and a number to return the call. The Center may contact me as indicated on the Registration page. A check mark in the appropriate box (e-mail and/or text message) indicates where I would like to receive appointment reminders.
❑ E-mail: ________________________________ ❑ Text Message: ___-___-_____
__________*Initials*

Contacting the Center
Oftentimes, Counselors and/or staff are not available by telephone and I understand I may leave a voicemail, to be returned at the earliest possible convenience.

Counselors at the Center are available by appointment only, and do not provide emergency or on-call services. My Counselor may not be available to me during an emergency, but will make every effort to respond to phone messages in a timely way. I understand that in emergency

situations, or if I need emergency services, I should call 911 or my local emergency response team. If I access emergency services, I understand it may be important for me to contact my Counselor so he/she can provide assistance or records relevant to my treatment.

I understand and am aware that e-mail and mobile phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. I understand that e-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. I understand faxes can easily be sent erroneously to the wrong address. If I choose to not participate in such means of communication now, and send an e-mail in the future, it will be understood by the Center and/or Counselor I wish to begin communicating in this fashion until written notice otherwise. I will not use e-mail or faxes for emergencies.

While text messaging with my Counselor can be an efficient means of communication, I understand such communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. I understand it is the policy of the Center to limit text messaging to scheduling and arranging appointments. If I choose to not participate in such means of communication now, and send a text message in the future, it will be understood by the Center and/or Counselor I wish to begin communicating in this fashion until written notice otherwise. I will not use text messaging for emergencies.

I understand that text messages, e-mails and voicemails, or transcripts of them, may be included in my professional record.
__________*Initials*

Social Media
I understand it is the policy of the Center to not permit Counselors to accept friend or contact requests from current or former clients on any social networking site (e.g., Facebook, Twitter, etc). Doing so can compromise my confidentiality and privacy, and blur the boundaries of the therapeutic relationship. Further, contact through social media (e.g., wall postings, @replies, etc) may not be read in a timely fashion.

The Center and/or Counselor may maintain a professional social media page and allow people to share posts and practice updates with other users. I understand as a client, I am welcome to view these professional pages, but linking myself (e.g., becoming a "fan" or "following") to these media is against Center policy as it may compromise my confidentiality. Further, I understand it is unethical for the Center and/or Counselor to solicit testimonials from current or former clients, and "friending," becoming a "fan" or "following" may be construed as a public endorsement.

I understand the Center and/or Counselors are not permitted to "friend," become a "fan," or "follow" current or former clients. If there are things I wish to share with my Counselor, I will bring them to the session. Exceptions to this can be made after consultation with another mental health professional and where there is clear therapeutic intent. In times of crisis, and to

ensure my welfare, the Center and/or my Counselor may access search engines and/or social media when usual means of communication do not work.

Attempted contacts via social media may necessitate such contacts as becoming a part of my medical record maintained by the Center. If I need to contact the Center or my Counselor, I will do so via phone, my Counselor's e-mail or text message, and will reserve this for administrative tasks only.

Note that clients should be able to subscribe to pages via RSS without becoming a Fan and without creating a visible public link, but again, confidentiality cannot be guaranteed.
__________*Initials*

Business Review Sites
I understand the Center and/or Counselor may be on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If I should find the Center and/or Counselor on any of these sites, I understand that this listing is NOT a request for a testimonial, rating, or endorsement from me.

It is unethical for the Center and/or Counselor to solicit testimonials. While I have the right to express myself on any site I wish, the Center and/or Counselor is prohibited from replying. The Center and my Counselor urge me to take my own privacy as seriously as they take their commitment of confidentiality to me. I understand that if I am using these sites to communicate indirectly with my Counselor about my feelings about our work, there is a good possibility that my Counselor may never see it. If I do choose to write something on a business review site, I understand I may be sharing personally revealing information in a public forum.
__________*Initials*

Location-based Services
I understand using location-based services on my mobile phone may compromise my privacy. The Center does not place itself as a check-in location on various sites (e.g., Foursquare, Gowalla, Loopt, etc.) I understand that having GPS tracking enabled on my device may make it possible for others may surmise that I am a therapy client due to regular check-ins or by others simply being aware of the Center. I am aware of this risk if intentionally "checking in" and if I have a passive location-based app enabled on my device.
__________*Initials*

Consultation and Collaboration
I understand my Counselor consults with other professionals regarding clients and may do so regarding my case; however, I understand a client's name or other identifying information that may be disclosed is limited. Further, I understand that the Center is housed in an office suite with other private practices. Each qualified mental health practitioner has established his or her own private practice, is their own business entity, and administers his or her practice separately from the Center, and the Center is separate from the other private practices.
__________*Initials*

Emergency Contact
In the event of an emergency or urgent medical need, I authorize the Center to request an ambulance to take me to a hospital for medical or psychiatric care, and notify my emergency contact listed on the Registration form. In the event I may be unable to safely leave, but have no emergency or urgent medical need (such as presenting under the influence of a substance or alcohol), the Center may notify my emergency contact listed on the Registration form in order to be assisted leaving and being safe.
__________*Initials*

Professional Records
I understand the law and standards of the professional mental health community require the Center to maintain Protected Health Information about me in my record. Except in unusual circumstances that disclosure would physically endanger myself and/ or others, or makes reference to another (unless such other persons is a healthcare provider) and the Center believes that access is reasonably likely to cause substantial harm to such other person(s), I may examine my record if requested in writing.

I understand that my records are maintained electronically with a company that specializes in mental health records, and the requirements to keep them secure and confidential. With this service, the Center is able to provide self-scheduling of appointments, set appointment reminders, complete forms, and more. However, I understand this convenience poses risks, such as individuals that are not authorized to view my information may be able to do so, such as information technologists or hackers. To mitigate this risk, the company providing this service to the Center has established security protocols that can be read at https://www.simplepractice.com/security. Finally, I understand that by my using the electronic health record, without intention, I can disclose my health information. In order to "do my part" in maintaining privacy and confidentiality, including, but not limited to: 1) Not giving my username to anyone, 2) Using a complex password, 3) Regularly changing my password, 4) **NOT** giving my password to anyone [note: the Center will **NEVER** ask you for your password], 5) Use the security questions within the electronic health record, and 6) not allowing the computer I access my electronic health record on to store my username and/or password.

Because these are professional records, I understand they can be misinterpreted and/or upsetting to untrained readers. I understand that for this reason, and because the Center is legally responsible for maintaining my confidentiality, only a summation of my record may be

released. All other professionals will receive a summation of my treatment (which incurs a fee). I understand the first copy is free and all those thereafter will result in $1.00 per page to me. __________*Initials*

I have read and understand the above, have had an opportunity to ask questions about this information and received satisfactory answers, and I consent to counseling, mental health assessment, evaluation, and/or testing. I also attest that I have the right to consent for counseling, mental health assessment, evaluation, and/or testing. I understand that I have the right to ask questions of my Counselor about the above information at any time.

____

Signature of Client Date

____

Signature of Legal Representative and Relationship to Client Date