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

_____-_____-_____

❑ Home ❑ Mobile ❑ Work

Do not leave ❑ messages, ❑ text message.

Secondary Phone:

_____-_____-_____

❑ Home ❑ Mobile ❑ Work

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

COUNSELING 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 *Counseling 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*

Counseling Services and Consent to Treatment

I understand that once the evaluation period is complete, if counseling is begun, I will be able to schedule a one-hour session (approximately 60 minutes) per week, though some sessions may be longer or more frequent. Once an appointment is scheduled, whether an individual or group session, I understand that I am obligated to pay for it unless I provide at least a 24-hour advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions and those appointments not kept.

I understand the purpose of counseling is to identify the concerns that are causing me distress, to create goals and objectives to help resolve that distress and/or concern, and achieve positive results through a process of personal change.

I understand there risks involved with counseling, such as remembering unpleasant memories, arousing unpleasant emotions, including embarrassment, or altering close relationships. Counseling often involves difficult decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of life. Sometimes a decision that is positive for one person or family member is view quiet negatively by another person or family member. Additionally, I acknowledge there are no guarantees that counseling will be effective and no guarantees have been made by the Center or Counselor. I also acknowledge that attempting to resolve concerns that brought me into counseling may reveal underlying issues, or result in changes not originally intended.

Reasonable alternatives and additions to counseling, psychotherapeutic treatment and/or service for my concern may be medication or another treatment modality. I understand the Center and its Counselors do not prescribe medication and this will necessitate seeing another provider with which my Counselor will work.

I know of no reasons I/he/she/we should not undertake this counseling and I/he/she/we agree(s) to participate fully and voluntarily because I believe it may be helpful to personal growth, development, and healing. I am not participating because of pressure from anyone else. I have asked any questions I may have, received satisfactory answers, and authorize the staff of the Center to render individual/group/family psychotherapeutic

treatment and/or service to _____ _____ (*name of person receiving counseling*), whose relationship to me is (*check one*) __ self, __ child, __ spouse, or __ other (*specify*) _____.

I understand that I may withdrawal consent for counseling at any time by providing a written request to my Counselor.

I certify that I have given my true name and identifying information and have given truthful statements to written and oral questions from the Center, its Counselors, staff, or volunteer workers.

_____*Initials*

Professional Fees

I understand that the fee is $125.00 for individual sessions. Diagnostic interviews are an hour and a half and incur a charge of $250.00. Mental health assessments, evaluation, testing, and report writing are $125.00 per hour. In addition to session fees, the Center charges fees for other professional services you may need, though that fee is based on the quarter hour. Other services may include, but are not limited to, report writing, review of testing/assessment results, correspondence, contact with insurance companies, other professionals, including all telephone conversations lasting longer than five minutes, and preparation of records or treatment summaries.

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 understand that I am financially responsible for this treatment and that the Center does not contract with any third party payors (health insurance). I understand the Center will assist me in obtaining reimbursement from a third party payor (health insurance) if I request such assistance it, but cannot guarantee any reimbursement.

I understand payment is due at the time services are rendered, unless agreed otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of financial hardship, I understand the Center may be willing to negotiate a payment installment plan.

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*

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

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*

Confidentiality from You

I agree to forever keep confidential all names and identifying information of those participating in Center events or psychotherapy, excluding professional staff. I understand the Center cannot guarantee other participants/clients will maintain my confidentiality.

_____*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