Tree of Life Behavioral Health

190 Lime Quarry Rd Madison AL35758
256-278-2802

Counseling Registration

1. **Please provide the following information for the client. If client is 14 years or older, please complete the form together.**

Client Name (First, Middle, Last): Date of Birth: Assigned Gender (M/F):

Pronouns: Sexual Orientation:

Race: Preferred Language: Social Security Number:

Street Address: Apt/Unit #: City: State: Zip Code:

Mobile Phone: Home Phone: Work Phone:

Email Address: Preferred contact method:

☐ Mobile ☐ Home ☐ Work ☐ Email

Referred By:

2. **Emergency Contact Information**

Emergency Contact Name: Relationship:

Address:

Phone Number: Alternate Phone Number:

3. **Please list all individuals/ agencies that we have your permission to speak with regarding the continuity**

of care associated with the client.

Individual/Agency: Telephone Number:

Individual/Agency: Telephone Number:

Individual/Agency: Telephone Number:

4. Primary Care Physician

Family Physician: Telephone Number:

5. Medical Insurance

Do you have Medical Insurance? ( )Yes ( )No

PRIMARY INSURANCE

Primary Insurance Company: Member ID/Policy #: Group Number:

Effective Date: Insured Name: Insured Date of Birth:

Insured Sex: Client Relationship to Insured: Insured Telephone Number:

( )F ( ) M

Insured Street Address: Insured City: Insured State: Insured Zip Code:

SECONDARY INSURANCE

Secondary Insurance Company: Member ID/Policy #: Group Number:

Effective Date: Insured Name: Insured Date of Birth:

Insured Sex: Client Relationship to Insured: Insured Telephone Number:

( )F ( ) M

Insured Street Address: Insured City: Insured State: Insured Zip Code:

*** PLEASE NOTE THAT WE DO NOT FILE INSURANCE FOR OUR PSYCHIATRIC TESTING. SPEAK WITH THE FRONT OFFICE FOR PAYMENT PLANS. ***

COUNSELING INTAKE FORM

1. What concern(s) bring you in today?

2. How long have you had this concern?

How severe is the concern?

(0) None (1) Mild (2) Moderate (3) Severe (4) Very Severe

Is this concern affecting your family, life, work, and/or sleep? (_)Yes (_) No

If yes, please explain how it affects your family, life, work, and/or sleep.

Have you previously seen a therapist/counselor for this concern? If you, please enter previous therapist/counselor information.

3. Have you had any recent stressful events or significant life changes? (i.e. recent death, divorce, job loss)

4. What goal(s) do you have for this session?

5. Mark all current symptom that apply for you:

	Answer (Yes or No)	Notes/Comments
Difficult falling/ staying asleep		
Sleeping too little or too much		
Daily feeling of sadness that does not		

go away		
Panic/Anxiety Attacks		
Problems concentrating		
Mood fluctuates up and down		
Remembering upsetting things constantly		
Upsetting thoughts I cannot get out of my head		
Repetitive behaviors I cannot stop		
Constant Worrying		
Appetite Issues		
Sexual Abuse		
Physical/Verbal Abuse		
Feeling tired almost all day		
Questions about sexual identity		
Feelings of low self-worth		
Risky Behaviors/ Activity		
Difficulty controlling temper		
Difficulty maintaining a job		
Difficulty paying for basis expenses		
Thoughts of killing and/or harming myself		
Attempts to kill and/or harm myself		
Hear or seething's that other people do not		
Avoidance		
Excessive Energy		
Libido Changes		
Impulsivity		

6. Desire for treatment:

◯ Someone forced me into seeking counseling. I am doubtful that counseling can help or I don't I am think I need any help.

◯ I am prepared to undergo counseling. I still have some doubts, but there are things that I would like to change in my life.

◯ I am reluctant to undergo counseling. I am unsure if if there is anything I can change in my life, however, willing to talk with someone.

◯ I am actively doing things to make changes in my life. I have been in counseling before and I want to continue or I am looking for additional support.

MEDICAL AND HEALTH HISTORY

1. How would you rate your physical health?

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Do you have any of the following: (Check all that apply)

   ☐ Diabetes ☐ Cancer ☐ Headaches/Migraines ☐ Liver Disease

   ☐ Heart Disease ☐ Stroke ☐ HIV/AIDS ☐ High Blood Pressure

   ☐ Thyroid Disease ☐ Alcohol/Substance Abuse

3. Any other major medical conditions? ☐ Yes ☐ No

   If yes, please list:

4. Do you have chronic pain? ☐ Yes ☐ No

   If yes, please list:

   If yes, please list pain medication:

5. List all medications you (client) are taking, including any over-the-counter medications, herbs, and/ or vitamins:

	Medication	Dosage	Reason for taking?
1.			
2.			
3.			
4.			
5.			
6.			

6. Do you have any known allergies? ◯Yes ◯No

   If yes, please list:

	Allergy too?	Reaction
1.		
2.		
3.		

7. Do you smoke? ◯Yes ◯No

   If you smoke:
   Packs/Day: _____ Years: _____

8. Do you drink alcohol? ◯Yes ◯No
   If you drink alcohol:
   Drinks/Day: _____ Years: _____

9. Do you drink caffeine? ◯Yes ◯No
   If you drink caffeine:
   Cups/Day: _____

10. Do you have any concerns about sleep? ◯Yes ◯No

11. Have you been diagnosed with a psychiatric condition? ◯Yes ◯No

    If yes, please list:

    _____

    _____

12. Do you engage in exercise? ◯Yes ◯No
    If yes, please list:

    Exercise frequency:

    _____

    Exercise type:

    _____

SOCIAL HISTORY

1. Marital Status:
   ◯ Single ◯ Married ◯ Divorced
   ◯ Widowed ◯ Separated ◯ Not Applicable

   Name of spouse/significant other: _____

   If married, date of marriage: _____

   Previous divorces? ◯ Yes ◯ No
   If yes, date of divorce: _____

   How is your relationship with your partner?
   ◯ Excellent ◯ Good ◯ Fair ◯ Poor

   Are you sexually active?
   ◯ Yes ◯ No

   Do you have children?
   ◯ Yes ◯ No
   If yes, how many? _____

   Are you satisfied with your family life?
   ◯ Yes ◯ No

   Are you employed?
   ◯ Yes ◯ No

   Occupation: _____

   What is the highest level of education you completed?
   _____

2. Do you consider yourself spiritual/religious? ◯ Yes ◯ No
   If yes, describe faith/spiritual practice and/or affiliated entity(s):
   _____
   _____

3. Have you ever been arrested?
   If yes, when and offense?
   _____
   _____
   _____

FAMILY HISTORY

1. Who currently lives in the home with you?

2. Who are your siblings, and what are their ages?

3. Were you adopted?
   If yes, at what age?

4. If you have children that are adopted, at what age was the adoption? What information do you have about the history of the biological parents and the child's history before the adoption?

5. Is there custody paperwork? ☐Yes ☐No
   If so, is DHR involved? ☐Yes ☐No
   Please list DHR caseworker: _____

6. Do you (client) have a family member(s) with a history of:

	Answer (Yes or No)	Father	Mother	Sibling(s)	Grandparents(s)
Alcohol/ Substance Abuse					
Anxiety					
Depression					
Eating Disorder					
Obsessive Compulsive Disorder					
Schizophrenia					
Suicide					
Diabetes					
Heart Disease					
Stroke					
Liver Disease					

Cancer					
HIV/AIDS					
Thyroid Disease					
Headaches/Migraines					
High Blood Pressure					
Others:					

If other, please specify:

Additional Information

1. Please provide any additional information you deem important for therapist to know.

*** A COPY OF DRIVER'S LICENSE, INSURANCE CARD, AND CUSTODY PAPEWORK THAT APPLIES TO THE CLIENT WILL BE REQUIRED***

Section 1: Notice of Privacy Practices

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

A. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

B. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

C. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity

to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHT WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so. Please review notice of Possible Subpoena, Court Order, and/or Request for Court Appearance Contract provided below.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Client Printed Name (age 14 or above): _____

Client Signature (age 14 or above): _____

Date: _____

Parent and/or Guardian Printed Name: _____ Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____ Parent and/or Guardian Signature: _____

Date: _____ Date: _____

Section 2: Informed Consent For Professional Counseling Services

YOUR RIGHTS AS A CLIENT

1. You have the right to ask any questions about happenings or procedures used during counseling. Your counselor shall explain the reasons and usual methods to you.

2. You have the right to confidentiality. Within certain limits, information revealed by you during counseling will be kept strictly confidential and will not be revealed to any other person or organization without your written permission. We encourage strict confidentiality with all marital, family, couples and group therapy sessions. You should realize that other participants (i.e., spouses, siblings, group members, etc.) are not legally bound to maintain this privilege and might subpoena counselor's notes, which could compromise your privacy.

3. There are certain situations in which any licensed mental health professional is required by law and ethical code to reveal information obtained during counseling to other's persons or agencies-without your permission. Your counselor is not required to inform you of any actions in these circumstances.

Such situations are as follows:

A. If you threaten bodily harm or death to another person, your counselor is required by law to inform the intended victim and/or appropriate law enforcement and social service agencies.

B. If you threaten bodily harm or death to yourself, your counselor is required to attempt to persuade you not to do so, And if you do not convince your counselor that you will protect yourself, your counselor must inform other appropriate persons of your self-destructive intentions.

C. If a court of law issues an order or subpoena, your counselor is required to provide the information specifically described in the subpoena or court order.

D. If you are in counseling or being tested by order of a court of law or DHR, certain rights may not apply, and the results of the treatment or test ordered data must be submitted to the court or DHR.

E. If you reveal information about known or suspected physical/sexual abuse or neglect of a minor child, or mentally incapable or elderly adult, your counselor must report the data to appropriate authorities.

D. You have the right to decline participation in the use of certain therapeutic techniques, psychological test administration, or medication. Your therapist/psychiatrist shall inform you of his/her reasons to utilize these measurements and shall describe any risks that your therapist/psychiatrist is aware of and will remain open to issues that are of concern to you.

E. Permission to record electronically must be authorized by you in writing. Clients are prohibited from recording counseling sessions without prior written consent from you counselor.

F. You have the right to review documents and records in your counselor's file which is a record of your treatment and financial and/or insurance documents. The counselor also has the right to reject such requests.

G. You have the right to end counseling at any time without moral, legal or financial obligation (other than the balance due). If you wish, your counselor will provide you with names of other qualified mental health professionals. Treatment may be terminated by your counselor as a result of your failure to comply with clinical treatment plans and goals or of your failure to abide by administrative policies, including failure to pay for services.

H. Please be aware that records are not kept indefinitely at Tree of Life Behavioral Health. Records will be destroyed

in a manner consistent with upholding client confidentiality.

I. Clients receiving care thorough an individual contracted to Tree of Life Behavioral Health agree that they will not hold Tree of Life Behavioral Health or its partners liable for any services performed by a contracted individual.

J. Counseling may involve the risk of recalling unpleasant memories. Intense feelings may also be aroused. These should be promptly discussed with your counselor.

K. If counseling is being provided to a child placed with a foster parent, the Department of Human Resources gives consent for all pertinent information to be provided to/shared with the foster parent while the child remains in their care.

Please note that your counselor is not a physician and cannot prescribe medication or perform any medical procedures. Please note that your counselor is not an attorney and cannot provide you with legal counsel or advice.

If you have read and fully understand all of the above information and agree to receive counseling from your therapist, please sign below.

ACKNOWLEDGEMENT OF UNDERSTANDING OF INFORMED CONSENT

Client Printed Name (age 14 or above): _____

Client Signature (age 14 or above): _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Section 3: Telehealth Consent Form

Tree of Life Behavioral Health TELEHEALTH CONSENT

190 Lime Quarry Rd. Suite 111

Madison, Alabama 35758

(256) 278-2802

http://treeoflifebehavioral.com

Client Name:_____ Date: _____

Therapist: _____

Telehealth involves the use of electronic communications to enable mental health professionals at different locations to connect with individuals using interactive video and audio communications. Telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. I understand that I have certain rights with respect to telehealth, as described below.

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my session is confidential. However, the limits to confidentiality still apply, including, but not limited to, reporting child/elder abuse, expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

2. I also understand the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent, just the same as in face-to-face office visits.

3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. Tree of Life Behavioral Health takes all precautions by using HIPAA-compliant secure, encrypted audio/video transmission software to deliver telehealth.

5. I understand telehealth may not always be possible. Disruptions of signals or problems with Internet's infrastructure may cause broadcast and reception problems (i.e. poor picture or sound quality, dropped connections, audio interference) that prevent interaction between therapist/counselor and client.

6. I hereby release and hold harmless Tree of Life Behavioral Health and all members (contracted employees) of my care team from any loss of data or information due to technical failures associated with the telehealth service.

7. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no result can be guaranteed or assured.

8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes, and they have agreed to all confidentiality practices of Tree of Life Behavioral Health.

9. The video conferencing technology used for a session will not be the same as a direct client/therapist visit due to the fact that I will not be in the same room as my therapist.

10. Tree of Life Behavioral Health counselors will bill insurance for telehealth services as applicable, and all standard

insurance co-pay rates will be applied. In the event that insurance does not cover telehealth, the client and/or guarantor will be responsible for all charges.

By signing this form, I certify:

- That I have read or had this form explained to me, and all my questions have been answered to my satisfaction.
- I understand the risks/benefits of telehealth and agree to participate in telehealth sessions with my therapist.
- I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented health care facility in my area.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client Printed Name (age 14 or above): _____

Client Signature (age 14 or above): _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Therapist/Counselor Printed Name: _____

Therapist/Counselor Signature: _____

Date: _____

Section 4: Notice of possible Subpoena, Court Order, and/or Request for Court Appearance Contract

Please be advised that this contract is binding if a Subpoena, Court Order and/or request for court appearance is processed and received, citing you or your child as litigant in court proceedings. Contingencies required by therapist's involvement in litigative action can be contraindicative to the therapeutic relationship.

Being sufficiently advised of this notice I, _____, hereby agree/understand the following conditions in relation to TREE OF LIFE BEHAVIORAL HEALTH.

I understand that confidentiality of therapy at Tree of Life Behavioral Health is governed by the statutes set forth by AL Code 1975 34-8a-1, and the Regulations Governing Professional Counselors, Chapter 255-x-2-06 relative to Privileged Communication. This privilege is considered the same as that existing between client and attorney, and can only be waive by authorization from the client to release information, or when the client is considered dangerous to self or others, or by judicial order.

I understand that the directives of this Subpoena/Order/Request require my therapist to be unavailable for other clients who are involved in ongoing outpatient therapy, and I agree to pay the hourly court rate, or of any portion thereof, plus expenses in order for him/her to satisfy the contingencies of the Subpoena/Order.

I understand that my attorney is responsible for scheduling my therapist as a witness in these proceedings. Whether or not my therapist testifies, in a timely fashion or not, within 48 hours from schedule, I will be billed and agree to pay the total amount for my therapist's time. I also understand that I will be responsible for payment of court fees even if my attorney did not issue the Subpoena/Order due to my name or my child being listed as litigant.

I understand that my health insurance cannot be filed for any portion of the above expenses, relative to the Subpoena/Order served to my therapist.

I agree to pay an advance deposit for court testimony and related activities. The current deposit is $2,000.00 and must be paid in full one week before the court date. The amount of this deposit is subject to change, based on the standard of practice for Tree of Life Behavioral Health. The amount of the deposit required will be commensurate with the date that the Subpoena or Court Order is received. Additionally, I agree to pay the balance for court related expenses within 30 days from the time services are rendered. A portion of this amount is refundable if canceled up to 48 hours before the agreed upon date. I agree to all terms and conditions of payment and collections, and in case if default, to pay all costs of collection or attempts to collect including but not limited to reasonable attorney fees and court costs. Tree of Life Behavioral Health reserves the right to retain a Collection Agent, to notify the Credit Bureau and to initiate proceedings in Small Claims Court. This agreement is governed by the laws of Alabama.

I understand that no civil or criminal action may be brought against my therapist, the professional or administrative staff of Tree of Life Behavioral Health or consultants for providing any records, reports, testimony, opinions, recommendations, or data, verbal or written, which resulted as consequences of a request for or response to a Subpoena, Court Order or litigative proceedings. I understand that this release does not have an expiration date and will remain active/valid even after my case is closed for services with Tree of Life Behavioral Health.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client Printed Name (age 14 or above): _____

Client Signature (age 14 or above): _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Section 5: Refusal of Notice of Possible Subpoena, Court Order and/or Request for Court Appearance Contract

I, _____, are refusing the sign a notice of possible subpoena. Due to this, your counselor will not under any circumstances work with your attorney, or testify in court your behalf.

This contract is legal and binding and is indicating that without a signed copy of a NOTICE OF SUBPONEA no counselor at Tree of Life Behavioral will communicate in any way with the legal system.

I, _____, are refusing to pay for forensic services by refusing to sign the notice.

In doing so, you are promising that no agent of yours will ever contact Tree of Life Behavioral Health asking for records or information and you are promising that no counselor at Tree of Life Behavioral Health will ever be subpoenaed to court.

If you would like our professional services, you must sign in Notice of Possible Subpoena, Court Order, and/or Request for Court Appearance Contract.

By signing below, I _____, am indicating that I am refusing to pay for legal and/or professional services with Tree of Life Behavioral Health and by refusing to sign the necessary paperwork to obtain forensic services am promising that I will not request any agent of Tree of Life Behavioral Health to ever participate in any legal manner.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client Printed Name (age 14 or above): _____

Client Signature (age 14 or above): _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Section 6 Credit / Debit Card Payment Consent

You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other contractual agreements apply. There will be a $25 fee for payments returned as non-sufficient or non-payable. All services will be bill to you, your guarantor, or contracted insurance plans by our office staff.

Client name: _____

(Card holder) Name on card if different than client: _____

Card Type: _____

Security Code: _____

Card Number: _____

Expiration Date and Zip Code: _____

PLEASE NOTE: A $50 to $150 fee will be charged to the credit card of file if you are -

1). more than 15 minutes late or more for any reason,

2). Cancel less than 24 hours in advanced,

3). No show for the scheduled appointment,

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Printed Name (age 14 or above): _____

Client Signature (age 14 or above): _____

Date: _____

Guarantor Printed Name: _____

Guarantor Signature: _____

Date: _____

Section 7: Slide Scale Fee Information

PLEASE READ CAREFULLY if you would like to receive sliding scale payments.

I understand that TREE of LIFE BEHAVIORAL HEALTH offers sliding scale payments to help patients who are unemployed, uninsured or under insured to obtain mental health services.

I understand that my counselor's normal rate is up to $150 per session for their services and they only receive a percentage of that. I understand that falsifying information on this form is grounds for immediate discharge and will prevent other individuals who may need this sliding scale slot from obtaining the service they need as each therapist can only offer a limited number of sliding scale slots.

I hereby certify that my HOUSEHOLD income is $ _____ (this includes all members of my family living in my household). I also understand that I must provide proof of income to receive sliding scale services.

I understand that, based on my income and the fees listed, my sliding scale payment will be $_____ per session and this must be paid at the time of service.

If you have no income in your household, meaning you do not personally have a job, and you do not have a spouse, parent or other individual living in your home with you helping with expenses, please check box below.

☐ I certify that I have no income at this time. I understand that my payment will be $50 per session if I have no income. This is the least amount we accept for payment.

☐ I understand that if my income level changes during the time I am receiving services, I will notify my counselor and the fees will change accordingly.

☐ Less than $49,000 = $50*

☐ $50-$59,000= $60

☐ $60-$69,000= $70

☐ $70-79,000= $80

☐ $80,000-$100,000= $100

☐ $100,000+= $150

Client Printed Name (age 14 or above): _____

Client Signature (age 14 or above): _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Guarantor Printed Name: _____

Guarantor Signature: _____

Section 8: Please Read the Following Carefully and Initial to Acknowledge your Agreement

Filing your insurance is a courtesy we provide for you. Since your insurance policy is a contract between you and your insurance company, the Guarantor/Client/Guardian is will responsible for co pays and unpaid balances or charges that are not covered by your insurance carrier.

Only initial clauses you agree to. Understand that if you do not agree to certain clauses below, we may not be able to bill your insurance and cash pay will be required. Also understand that failure to agree to certain clauses may result in an inability for Tree of Life Behavioral Health staff to treat you.

FINANCIAL AGREEMENT:

I hereby assume full responsibility for all charges incurred for professional services rendered by my provider, unless the services are deemed "paid in full" because of contractual agreement between my provider and my insurer. Payment is due at the time of service. Initial here:_____

GROUP AND INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS:

I authorize my health insurance benefit plan to pay directly to my practitioner at 190 Lime Quarry Rd Suite 111 in Madison Alabama. The medical/psychiatric benefits, if any, otherwise payable to me for their services as described on the claim but not to exceed the chares for those services. I understand I am financially responsible for charges not covered by this agreement. Initial here:_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize my practitioner to release any medical, psychiatric, infectious disease or drug and/or alcohol related information to my referring physician, other healthcare providers within my provider and referral sources for diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information to the insurance company with whom I have medical benefits for filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time. Initial here:_____

RECORDS:

Your client records are property of Tree of Life Behavioral Health and shall be treated as confidential. To insure quality record maintenance and client confidentiality, Tree of Life Behavioral Health, will maintain your records using Theranest, an online HIPAA encrypted database and mental health practice management web-based software package and/or paper. To comply with State and Federal Laws regarding patient confidentiality, your records will not be released without the properly executed written consent. Everything about your care will be held in strictest confidence. If you choose to have your provider(s) keep a third party informed of your progress in counseling, it will be necessary to complete the following Release of Information form that will be kept on file. Initial here:_____

CONSENT FOR TREATMENT:

I authorize and request my practitioner to carry out psychological and/or medical exams, treatment and/or diagnostic procedures and tests which now, or during the course of my treatment become available. I understand the purpose of the procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand

that is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. Initial here:_____

CONFIDENTIALITY:

I understand if my therapist believes that I am in physical and/or emotional danger and/or I am a danger to another human being that my therapist is required by law to contact medical and/or law enforcement personal to prevent harm to me or another person, and my contact the person in danger. Initial here:_____

EMERGENCIES:

During office hours, let the office staff know that you have an emergency and the nature of the problem and one of them will try to contact me. If I am unable to be contacted and/or you believe it is a life threatening emergency please call 911 and/or go to your nearest local emergency room, where the staff can offer assessment and treatment. After office hours, if you need after-hours emergency interventions, call 911 or go to your nearest local emergency room, where the staff can offer assessment and treatment. Initial here:_____

STAFF CONSULTATION:

I understand and authorize staff to discuss my case with other staff within Tree of Life Behavioral Health when necessary to improve my quality of care. I understand that staff periodically present cases at staff meetings to gain the knowledge and expertise of the other licensed professionals on the treatment team and this is done to improve my care and to expand the knowledge of my provider, so they can better aid and help me.

Initial here:_____

TELEPHONE CONSULTATIONS:

Our staff is available to you in crisis 24 hours a day. However, you may be charged for telephone consultations with your provider in excess of 5 minutes. If returning a call outside of normal business hours, there will be a fee for this contact and this is not reimbursable by your insurance company. The cost is $2.33 per minute and will be added to your account balance. Your insurance company may or may not cover charges for extended phone calls. Your provider may not always be available for afterhours crisis calls and you may have to talk to on call staff if your provider is not available. Cost will vary depending on the on-call staff's policies and procedures. Initial here:_____

TEXT MESSAGE REMINDER:

Tree of Life Behavioral Health provides clients with automated text message reminders to help clients keep up with their appointment dates and times. I understand that these messages will be sent to the phone number on file. I acknowledge that I would like these reminders sent to me. I also agree to front office staff communicating with me via text about my appointments. Initial here:_____

TEXT MESSAGE COMMUNICATION:

Text message communication is not confidential or compliant with HIPAA regulations. I understand this and would still like to communicate with my therapist via text from time to time. I understand that Tree of Life Behavioral Health cannot guarantee the confidentiality of topics discussed with my therapist using this mode of communication.

I would like my therapist to communicate with me this way: _____
I would not like my therapist to communicate with me this way: _____

APPOINTMENTS:

I understand that any client (minor), 14 years or younger or does not drive themselves to the appointment cannot be left alone at appointments. A guardian must be present at the facility for the entirety of the appointment time. If the parent and/or guardian does not remain at the facility will risk termination of the counseling relationship at no fault and/or liability to the counselor and/or Tree of Life Behavioral Health. Initial here: _____

NO SHOW FEES:

I understand that my provider is an independent practitioner contracted under Tree of Life Behavioral Health. I understand that failure to cancel with my practitioner without 24 hours' notice will result in a No-Show Fee of $50-$150 without the sliding scale adjustment. Initial here:_____

I understand that if I am 15 minutes or more late to my appointment, a $50 - $150 fee will be charged to the card on file and your appointment will need to be rescheduled. Initial here: _____

I understand if I need to cancel an appointment, a minimum advanced notice of one full workday is required. If the appointment is canceled in less than one full workday a $50 fee will still apply. Initial here: _____

TERMINATION:

Ending therapy may be initiated by you as the client, or as legal guardian o the client or myself as the therapist. In either event, a final session is strongly recommended to explore the ending process itself. This can be a useful conclusion to treatment. Referrals to other providers or other suggestions can be offered at that time. Initial here:_____

RECEIPT OF PRIVACY PRACTICES:

My initials below indicate that I have reviewed a copy of the Privacy Practices of my provider and that I have been offered a paper copy for my further review outside the clinic upon my request. Initial here:

I have read this information in full and fully understand all clauses I have agreed to. Initial here: _____

Client Printed Name (age 14 or above): _____

Client Signature (age 14 or above): _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____

Parent and/or Guardian Printed Name: _____

Parent and/or Guardian Signature: _____

Date: _____